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BEREAVEMENT IN CHILDHOOD AND THE ROLE OF ATTACHMENT

By

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DECLARATION

I declare that this thesis is my own unaided work. It is being submitted for the degree of Doctor of Philosophy at the University of Bedfordshire.

It has not been submitted before for any degree or examination in any other university.

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BEREAVEMENT IN CHILDHOOD AND THE ROLE OF ATTACHMENT

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ABSTRACT

The purpose of this research was to utilise attachment theory in understanding the experience of bereavement in childhood. Research objectives were addressed by using a mixed method design. Study One explored how experience of bereavement in childhood relates to current attachment style in adulthood. This was a qualitative interview-based study utilising thematic analysis and a quantitative assessment of attachment styles. Twenty-four participants were employed. The established Experience in Close Relationships (ECR) questionnaire was used. The results through the thematic analysis indicated that people with different attachment styles provide different narratives about their childhood bereavement. This study provides evidence that this was so.

Study Two was a co-relational study employing 121 participants who experienced loss of caregiver in childhood. Four established questionnaires were used: Inventory of Complicated Grief (ICG; Prigerson et al., 1995), Experience in Close Relationships Questionnaire-Revised (ECR; Fraley, Waller, & Brennan, 2000), Separation Anxiety Symptom Inventory (SASI; Silove, Manicavasagar, O'Connell, Blaszczynski, Wagner, & Henry, 1993) and Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979). The results showed that complicated grief was

related to parental care and overprotection, separation anxiety, and adult attachment style. Anxious attachment style fully mediated the effects of parental bonding on complicated grief.

Study Three was a quantitative co-relational study to compare two groups of parents (with and without a bereaved child) on child behavioural differences and links between child behavioural problems and parental characteristics. Two hundred and forty participants were employed: 139 parents of children with bereavement experience and 101 without bereavement experience. Five established questionnaires were used: Child Stress Questionnaire (CSQ), Strengths and Difficulties Questionnaire (SDQ), The Parenting Scale (PS), Inventory of Complicated Grief (ICG), and Experience in Close Relationships Questionnaire-Revised (ECR-R). The results showed that child problems were closely associated to parental qualities.

It is proposed that this research can make a contribution towards utilising attachment theory in understanding the experience of bereavement in children.

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CHAPTER ONE
INTRODUCTION

This chapter consists of an introduction to the problem under investigation, and justifies the research objectives, research questions, and research hypotheses. Bereavement and grief are interchangeable terms, referring firstly, in the event of the death of someone valuable and loved and secondly, in the reaction to that loss. Often, it is a group experience that can be shared with others, e.g. family members (Neimeyer, 2006). Bereavement can also be defined metaphorically as a set of reactions to a significant loss, not by death, of a loved one, employment, a physical ability, or possessions, and one may experience sadness, anger, or relief during the bereavement process (America, 2012; Salters-Pedneault, 2010).

Bereavement or loss of someone close is one of the most difficult human life experiences. A bereaved person may experience psychological, physical, and spiritual problems during the grief process. Research shows that the death experience of someone very close, including parent, sibling, or friend is associated with different psycho-emotional reactions such as fear, depression, anxiety, guilt, pity, anger, and vulnerability (Thompson et al., 1998). Bereavement is a complex process that is considered normal and may be accompanied by a variety of emotional reactions, behavioural responses, and thoughts. In the course of bereavement, individuals may experience sadness, anger, or relief, and may also feel the urge to withdraw from other people or to seek out social support. Further, grief is a reaction to the loss of someone who is a very significant part of an individual's life, a loss that affects them emotionally as well as physically. It is a reaction and feelings to any loss that develops naturally, when someone or something very close departs forever (Melinda, 2012).

The grieving process varies from individual to individual. It may be healthy or unhealthy, with varying resolution times, but at the end everybody has to accept loss in order to move on in life. Normally, every grieving individual passes through these stages: shock and denial, intense concern, despair and depression, and recovery (McDonald, 1985). Bereavement is a common experience in individuals' lives but sometimes it becomes risky and complicated, resulting in intense depressions and reactions. Research shows that complicated reactions to bereavement may cause long-term illness. For example, stomach ache and problems in breathing are noted by Collin Murray Parks in the 1960s and 1970s and death rates, especially suicides in adolescents in the post-parental death period (Ward, 1976).

Bereavement in children and adults

Bereavement is a particularly difficult experience for children. According to the longitudinal British Cohort Study 1970, among 11,000 children born in 1970, 5% had faced the death of a parent or sibling by the age of 16. One in every 16 had experienced the death of a friend during childhood; in a survey of the Office for National Statistics by Fauth (2009) and in a study by Harrison and Harrington (2001), more than 78% of 11–16 year olds reported the death of a close family member or a friend. Grief is a cognitive and emotional response and research showed that parentally bereaved children develop mental health problems and present with impairment in various functions.

The relevant literature suggests that childhood bereavement may affect abilities of perception and cognition (Lifshitz, 1976), and that bereaved children may develop problems such as somatisation and school and behaviour problems (Balk, 1983). Bereavement may affect children's long-term development, health, and safety (Kirwin & Hamrin, 2005), although their reaction to bereavement

varies (Scott, 2004). Retrospective studies report that many psychologically distressed patients were bereaved siblings as children (Pollock, 1962).

Childhood bereavement experiences are not often understood and studied (Wilkins & Woodgate, 2005). Previously, children were considered to be less affected by death experience as they were regarded as not fully aware of death and loss, but recent studies contradict that (Oltjenbruns, 2001). Adults sometimes underestimate children's capacity to understand death and provide inappropriate explanations in order to protect them (Corr & Balk, 2010). That type of protection however is not helpful as it fails to facilitate children's awareness and coping with death.

To comprehend the bereavement experience in children, the concept of child understanding of death is very important. Although children under ten years old are considered to have a limited cognitive understanding of death, over the age of ten their understanding matures (Willis, 2002). Willis (2002) argues that as a child's cognitive processes develop with age, children become able to understand death as irreversible, permanent, and unavoidable, experiencing death in similar ways to adults.

Research shows that at the age of six to eight, children understand that everyone will die. However, the understanding of different features of death varies among individual children. These include finality (the sense that a dead person cannot be alive again), inevitability (we cannot avoid death), unpredictability (death time is not fixed and it may come at any time) (Brown, 1999). Goodman (1999) reported that different factors are involved in the maturation of death understanding and bereavement responses in children. These factors include the child's age, cause of death, the surviving adults' physical and emotional sensitivity, demographic background of the family, their financial and social

conditions, divorce or illness, behavioural problems of the child, family relationships, relationship with the deceased, and the quality of support services before, during, and after the death of a close one.

Death understanding in children is also affected by a child's anxiety in general and anxiety over death in particular (Slaughter & Griffiths, 2007). In the literature, the quality of the parent–child relationship is regarded as an important factor in determining the predisposition of the child towards anxiety and a mature understanding of death. Death of a parent is the most difficult bereavement experience a child may ever have. With the loss of the parent other family members are also bereaved and have their lives changed, so the whole world of the child changes as well (Silverman & Worden, 1992). Recent research on child bereavement shows that children who experience the death of a parent are at risk of developing psychological disorders that may continue into later life (Young & Papadatou, 1997).

In sibling bereavement, children show some what different problems such guilt, crying, anxiety, anger, and sadness. They also present with sleeplessness, social interaction problems like isolation, and feelings of abandonment, as well as low performance and conduct problems at school (Brody, 1998; Fanos, Little, & Edwards, 2009; Weller, Weller, Fristad, & Bowes, 1991). Furthermore, children continue to bond with the deceased (Normand, Silverman, & Nickman, 1996) although the surviving parent plays a great role in that.

Bereavement research is more focussed on adults while bereavement in children and adolescents has been ignored to an extent (Kandt, 1994). When studied, bereavement in children mostly refers to parental loss while studies on sibling loss are very rare (Sood, Razdan, Weller, & Weller, 2006). Moreover, those studies have focussed on children's immediate response to loss while long-term

effects of the loss, including vulnerability to psychological disorders, have been relatively ignored. As a consequence of lack of knowledge of the bereavement process in children, there are limitations in the supportive services available to bereaved children (Kirwin & Harnrin, 2005).

Researchers have proposed a variety of theories to explain the bereavement experience in children, which usually are extensions of theories of adult bereavement (Scott, 2004). Freud was the first to establish a grief theory, in the twentieth century, and proposed the basic concept of the grief process (Freud, 1961). He was of the opinion that the normal grieving process involves particular phases ending up with the bereaved disengaging from the deceased and moving on with life. In his *Mourning and Melancholia* (1917), Freud argued that the grieving process is successful when the Ego of the bereaved person is able to let go. When that does not happen bereavement is pathological and psychological, and somatic problems appear.

Freud confronted his theory in his personal life when he himself went through the experience of bereavement because of the death of his daughter Sophie. It was evident in a letter he wrote nine years after his daughter's death to console one of his friends who was mourning the death of his son. According to that letter, after experiencing the loss of a loved one, an individual feels lonely and helpless in finding a replacement and the individual remains in a stage of grieving deep down in their heart. Even when mourning proceeds towards the later stages of coping, still some sadness lives inside the heart and soul of the bereaved. This, according to Freud, is our wish to continue to keep the love bond with the deceased. Freud (1917, 1957) and other early psychoanalysts pointed out that the grieving process involves a contradiction: the experience of physical separation from the deceased while emotionally the deceased is still close and cannot be forgotten. Although Freud's grief theory has its limitations, it explains

the processes of cognition and emotion through which the bereaved individual finally accepts the reality of death and emotionally separates from the deceased while keeping the memory (Stroebe & Stroebe, 1997).

Studying bereavement experience in adults, Lindemann (1944) proposed a theory of three stages in the grief process: shock and disbelief, acute mourning, and resolution. The work of Lindemann is often credited as one of the first classic studies of grief. According to his theory, grief is categorised in two different forms: the first is normal grief and the second is abnormal grief. He considered abnormal grief to be a complicated, unresolved grief. He based his theory on his clinical experience as a psychoanalyst working with victims of the Second World War and encountering a variety of bereavement problems. He argued that grief should be expressed openly and accepted as a reality while delaying the grieving process causes a number of psychological complications.

In his work, Lindemann aimed that his clients achieved a positive resolution of the grieving process, involving liberation from the ties to the deceased, adjustment to the new circumstances without the diseased, and formation of new relationships as part of moving on in life. His research participants included adults who had lost their relatives in a hospital, particularly those who had lost loved ones during a hospital treatment described at the time as "psychoneurotic", as well as close relatives of armed forces personnel who had died. His participants also included those individuals who went through a painful bereavement experience when they lost their young close family members in the infamous fire at the Coconut Grove Nightclub, Boston, in 1942 in which 168 people died.

According to Lindemann, all those individuals did not go through an ordinary normal bereavement experience and often would need to go under psychological

therapy to support them in resolving their traumatic loss (Middleton et al., 1997). Criticising Lindenmann, Parkes (1996) suggests that more detailed information was needed on various aspects of Lindenmann's research, including the number of interviews he conducted with his participants and how long after the loss those interviews had been conducted. Nonetheless, Scott (2004) argues that Lindemann's work was highly significant in understanding bereavement reactions and grief stages in bereaved adults.

Kubler-Ross (1969) was the first to propose five stages of bereavement in her book *On Death and Dying* including numbness, denial, anger, blame, and acceptance. According to the author, these stages help us understand the general grieving process although not all bereaved individuals necessarily have to go through all those phases. *Denial and Isolation* is a defence mechanism against reality and the intensity of a shock – it is a temporary denying of pain. *Anger* is directed towards the dead person who causes us pain; although we know they should not to be blamed. Anger may be targeted against the doctors who treated the deceased. *Bargaining* is a kind of week defence against pain and an attempt to delay the death by better arrangements of doctor or facilities. *Depression* during the grief process is of two types. The first type is related to money, funeral arrangements, and family relief, while the second is related to personal feelings of separation to a closed one. Finally, a*cceptance* is the best way to face the loss while avoidance takes a long time to heal. Kubler-Ross emphasizes that although there may be other people around to provide support, the bereaved individual needs to face the loss by themselves. Kubler-Ross's grief theory has been popular in bereavement research, although one that was hardly understood and widely misused, according to Schuurman (2003).

After decades of studies on bereavement experience in adults, it was John Bowlby who included children in bereavement studies for the first time (Costa &

Holliday, 1994). Bowlby found a resemblance between a young child's (ages one to three) reaction to separation from the primary giver for an extended period of time and an adult's grieving process (Christ, 2000). The author (Bowlby, 1980) reported that children's reaction to a temporary separation from their primary caregiver for extended time duration is similar to how adults experience and respond to the loss of a loved one, such as that of a spouse. Children seem to think that the temporary loss is a permanent one and respond accordingly. Bowlby noted how many times children called for their mothers, how their behaviour changed in her absence, and how they showed longing for their primary caregiver in symbolic play.

Also, he noted that it was strange that after reuniting with their primary caregivers whom they were so eager to see again, some children showed disinterested indifference: such as they tried to hide their pain and feelings when they were hurt and even they did not allow their primary caregiver to try to give them relief and comfort (Bowlby, 1980). Further, Bowlby observed that hospitalized children showed similar behaviour and reaction to that of children experiencing bereavement due to the death of their attachment figure. Moreover, he noted that adults tend to react to permanent loss in similar ways – they long for the deceased, deny the irreversibility of the death, blame themselves for the loss, and behave like the deceased while responding to loss (Bowlby, 1980).

According to Bowlby's attachment theory (see next section), it explains that when a child is separated from the attachment figure, they go through different emotional phases: protest and anger, despair and yearning, and emotional detachment. When emotional detachment is reached, it remains even when their primary caregiver is reunited with the child. Bowlby suggests that older children and adults go through three similar stages in their grieving process:

yearning and searching, disorganization and despair, and reorganization. Bowlby understood grieving as separation anxiety (Stroebe et al., 1996), while Parkes (1970) extended Bowlby's model of grieving and included one more phase – the phase of 'numbness'. An important empirical base for the model of Bowlby and Parks (1970) was a number of interviews with widows aged 26–65 years of age with a varying duration of bereavement – ranging over 1, 3, 6, 9, and 12 months after the event of the loss. Their theory has played an important role in the field of bereavement counselling and support.

According to Rees (1997), the model of grief presented by Bowlby and Parkes focuses on the internal world of the person going through bereavement, mainly the experience of numbness, shock, and confusion. In the grieving process described by Bowlby and Parkes, the bereaved individual goes through a stage of numbness and shock, before they start longing for the deceased. This longing and looking around for the deceased is a major part of the whole mourning process in which the bereaved person tries to reassert their link with the deceased, feel their presence around them, or visit places that are associated with the deceased.

This important phase of yearning and searching in the Bowlby and Parks model distinguishes it from Freud's approach in which the focus is on the detachment from the deceased and the role of memories in that process. The continuation of the attachment bond to the diseased is a painful experience for the bereaved, necessary before the mourner finally detaches themself from the diseased and moves on in life. In that way the Bowlby and Parkes model follows the Freud's psychoanalytic theory, that the ultimate aim of the grieving process is the resolution of grief – detachment and acceptance of the reality of loss. This focus on final detachment is now widely accepted by bereavement experts (Walter, 1999). The grief theory of Bowlby and Parkes challenged past beliefs, shared by

Freud and Lindmann, that children's response towards death is less comprehensive than the adult response (Costa & Holliday, 1994).

Moreover, Furman (1974) proposed a grieving theory of three tasks resembling Bowlby's three-phase model. Those tasks included: understanding and coming to terms with the death, mourning, and resuming living. Both theories describe similar initial phases of bereavement ("yearning and searching" in Bowlby and Parkes, "understanding and coming to terms with the death" in Furnam) and both agree upon the finality of death and the loss. In his second task Furman proposed that the mourning process for parental death should be completed as that will prevent emotional problems in children later in their lives. Similarly, Bowlby (1980) in his second phase hypothesized that unresolved disorganization and despair after separation from the mother generates more problems for children in their later life. Finally, both theories agree also on the last phase of grief and propose that children should emotionally detach from the bereaved and move on in life when the bereavement process is successfully completed (Scott, 2004).

Furthermore, LeShan (1988) studied parentally bereaved children and also stated three stages in the bereavement process: denial, disorganization, and integration of loss and grief. This theory too is similar to Bowlby's and Furman's approaches, but she argued, very importantly, that in children the mourning process never ends (Costa & Holliday, 1994). This author suggests that children cannot avoid memories of their own birthdays, weddings, and various other events, and keep missing them making detachment very difficult. Other researchers also support that idea, arguing that the bereavement experience and grief response continue over time (Scott, 2004).

On the other hand, Worden (1991) did not follow the tradition of stage and

phase theories. Instead, he proposed that bereavement is a dynamic and active process. He presented a four-task model, including the tasks of admitting the loss, feeling the pain in grief, adjusting without the deceased, and withdrawing emotional energy and reinvesting in other activities. His tasks resemble tasks proposed by previous theories. Worden claims that he found this model very helpful in his research and counselling work, although he did not publish any empirical findings.

More recent studies conducted in the 1990s focussed more on the emotional aspects of the normative childhood bereavement experience as opposed to previous research focussing primarily on the mental health problems of the bereaved children. Some authors suggest that the grieving process in children follows phases that may be different for different individuals and prevalent themes that are particular to their own experiences, including, for example, shock and rejection, somatic problems, anger, guilt, jealousy, anxiety, fear, sadness, and loneliness (Groh, 1991). Most importantly, this author proposed that such themes can also be linked to the experience of non-bereaved children. Furthermore, Goldman (2001) proposed another four-stage model of grief that focusses on the normative process, including understanding, grieving, commemoration, and going on. He also adds to the grief-related themes suggested by Groh (1991) including nightmares, excessive worry, fears, frequent crying, and somatic complaints.

According to Oltjenbruns (2001), although important research has been done on bereavement experience in childhood in the past decades, further progress is required in understanding how a child experiences grief. Most recent research has generated additional concepts on childhood bereavement instead of focussing primarily on grief theory as the previous studies did (Scott, 2004). Focussing on different stages in the bereavement process does not explain some

important physical, behavioural, and psychological aspects of children's experience (Attig, 1996). Rather these stage theories are deprived of specification (Stroebe & Schut, 1998). Children go through a grieving process as adults do, but they do so in their own way that may be different from adults and may not be easy to comprehend. For example, how do children experience their participation in funerals and other death related rituals? Furthermore, schools play an important role in supporting and educating children about death, including those children who have the experience of bereavement (Corr, 1999).

In adults the most grieving and difficult experience of a bereavement is when a child dies and the parents go through the grieving process. Rando (1986) proposed that the normal grieving process and its stages cannot be applied to the parent going through the grief of loss of their child as parents are unable to accept the reality of their child's death. Child death seems to contradict the natural law suggesting that a child should outlive the parents. As parents face the loss of their child, their view of the future, their dreams and plans change as well. Even having more surviving children, the grieving process is difficult to bear as no one can replace the deceased child. This is very different from the experience of widows/ers who can remarry and easily move on in life with a new relationship (Rando, 1986).

Wortman and Silver (1989) proposed the challenging idea that in the grieving process grief has to come across the loss and suggested three different phases of the grieving process. Their model is very similar to the one proposed by Bowlby and Parkes, showing that the grieving process eventually accommodates the loss and distress is reduced overtime. This was the time when the literature on bereavement experiences started including parents as bereaved individuals. Parents started taking part actively by themselves in bereavement research as they wanted to share their experience and talk about their children's death to

other bereaved parents (Schatz, 1986). It was stressed that the bereaved parents should not be worked on to detach themselves from the bereaved child but rather they should be left to effectively continue to bond with the deceased child in order to address their emotional needs (Worden, 1991).

These ideas provide a set for new theoretical perspectives and new ways of understandings parental grief. Moreover, the continuing bond process has become the basis for further qualitative research. As Talbot (2002) argues in his study on bereaved mothers, healing and coping becomes easier when they continue to remember and connect emotionally with them. They adopt different ways to remember their deceased children such as writing poetry about them or their biographies, making memorials, and praying and lighting candles. Klass (1996) reports that such daily practices helped the bereaved father of a murdered daughter stay away from alcohol and fight his addiction.

In conclusion, three main theories emerge to clarify bereavement experience in children and adults: attachment theory, developmental theory, and trauma theory. This thesis focusses on one of them, the theory of attachment. However, it will be critically reflective of the idea that bereavement progresses through well-defined stages, as suggested by many researchers including Bolwby. Empirical evidence only partly supports the stage approach to bereavement (Barrett & Schneweis, 1981; Maciejewski, Zhang, Block, & Prigerson, 2007). Maybe the notions of bereavement tasks (e.g. Worden, 1991) as discussed above are more useful in addressing the fact that different individuals in different circumstances grieve in different ways. Research has also shown that continued bonds with the deceased can be an essential part of adaptive bereavement and healing (Field, 2006; Talbot, 2002). Neimeyer (2013) suggests that “stage” in grief should be understood in its theatrical sense where the bereaved tries to make sense of the loss rather than as an absolute course that has to be followed.

Introduction to attachment research

Attachment theory, over the past four decades, has provided a fruitful theoretical framework in developmental, social, and clinical psychology focussing on the link between interpersonal, emotional, cognitive, and behavioural problems (Cassidy & Shaver, 1999). Attachment theory emphasizes the role of relationships in human development "from the cradle to the grave" (Bowlby, 1980). Attachment theory drew from psychoanalysis, cognitive psychology, and ethology. According to psychoanalytic theory of personality, feelings of pain, anxiety, or conflict are the contents of the unconscious and they are undesirable or disagreeable. According to Freud (1917, 1957), our experiences and behaviours are influenced by our unconscious and we are unaware of it. Defence mechanisms protect the mind from difficult feelings as they bring anxiety and are intolerable for the conscious mind. Bowlby and the attachment theorists subscribe to this general idea of defence to avoid pain, although they adopt a more cognitive perspective.

According to attachment research, attachment develops from lifelong needs for security and safety which are directed towards a small number of special individuals. Research reveals that the attachment bond shapes an infant's brain, particularly when parents or primary caregivers are fully supportive and responsive, they enhance attachment security in their attachment relation to the child. Attachment theory suggests that bonding quality between a parent or a primary caregiver and the child greatly affects the child's reactions and feelings when they experience separations or loss including bereavement (Bowlby, 1988; Bretherton & Munholland, 1999). This section reviews important concepts and findings in attachment theory.

Attachment in childhood

Infants come into this world with behavioural systems that are complex and multifaceted. One of these systems, the attachment system, refers to the child's need for protection against danger and distress. The attachment system regulates the parent–child relationship in which the child is totally dependent on the caregiver for all its basic needs and cannot survive without them. Both caregiver and infant are active players in the attachment behavioural system, utilising their innate behaviours so that the caregiver provides protection and safety to the infant (Bowlby, 1988).

Child behaviours involve crying, smiling, talking, and seeking the caregiver after exploring the world around for a secure base. Infants start their attachment at birth and this is almost completed at about 3 years of age. However, attachment behaviour will keep developing including other relationships throughout the lifespan. The primary attachment relationships will influence all other interpersonal relationships as the attachment pattern to the caregiver will be primary and most often will continue to be active over time. Children need harmony and warmth in their relationship with their caregivers so that the latter provide a secure and responsive support base, a base that satisfies their emotional, as well as physical, care needs. Children need a few caregivers who respond to them sensitively throughout.

Attachment is instinctual behaviour that has survival value because it keeps the child in close proximity to the mother for protection from predators. According to Bowlby (1969), as a child develops biologically, they also develop psychologically, needing safety and support against fear and anxiety, needs that activate the attachment system towards the caregivers. Bowlby proposed that the attachment system has an important function: that the child needs to feel safe from external threats and does that as they find safe haven in the

attachment relationship with the caregiver. A child can face challenges when they feel secure in that relationship and can easily get access to support. However, a child becomes anxious when they separate from the attachment figure and normally will make every effort to reunite with that figure. According to attachment theory, various internal processes related to memory and emotions towards the primary caregiver in individuals are controlled by the attachment system (Siegel, 1999).

Human beings are naturally bound to develop and maintain emotional and social relationships as they cannot live without others (Bowlby, 1977). Psychological growth is dependent on interpersonal attachment relationship. Attachment theory provides a framework to understand intimate close interpersonal relationship arguing that the basic relationship of human beings is that between a child and its primary caregiver (Bowlby, 1977). That relationship influences human psychological well-being throughout the lifespan. Attachment theory offers a comprehensive view of the importance of early relationships in guiding expectations of others from infancy and throughout adulthood and emphasizes the role of relationships in human development “from the cradle to the grave” (Bowlby, 1980).

As infants are very young they cannot survive without an adult’s care, support, and supervision. According to Bowlby, an infant is dependent on an adult for its protection and survival, a fact that enables them to feel safe and explore the surrounding world confidently (Bowlby, 1969, 1988). Attachment research suggests that experiences with the caregiver in childhood provide mental templates (working models) that will affect the understanding of and reaction to substantial loss, including death, in both children and adults. Children develop internal working models of self and significant others as they experience positively or negatively the self and others in important events (Bowlby, 1969).

Future relationships will be based on such internal working models, which will remain active across the lifespan (Cassidy & Shaver, 1999).

Following Bowlby, Mary Ainsworth (1978) proposed that the attachment system sometimes deviates from the ideal prototype of security, which greatly depends on parental response. In her classic experimental studies involving young children and mothers, the Strange Situation studies, she observed how a child behaved and reacted both in a non-threatening situation when the attachment figure (mother) was available, then how it reacted when the attachment figure was physically absent. Ainsworth also observed how children behaved when their attachment figures or other strangers entered the room after separation from the mother.

Ainsworth and her colleagues described three major patterns of parent–child attachment on the basis of her Strange Situation experiments: secure attachment, ambivalent/anxious/resistant-insecure, and avoidant-insecure attachment. Securely attached infants showed moderate distress when their caregiver left the room and kept looking for her, while they smiled, approached their mother, and calmed down upon her return. Then they continued to explore their surrounding as they felt comforted by their caregiver's return and response. Avoidant infants presented an insecure attachment pattern style. They showed no signs of distress on their mother's separation while remaining engaged in playing. They also showed no interest in their caregiver when she returned, instead they avoided them remaining busy with their toys.

Ainsworth's third attachment pattern was the Ambivalent or Anxious or Resistant pattern. In this category infants clearly show insecurity in their response. They were significantly distressed throughout the procedure, although distress levels varied, including when they entered the room, when they separated from their

mothers, and even when their mothers returned. They showed no comfort after the reunion with their mothers and resisted physical contact with her while. These children became very anxious when their mothers left the playroom while they had shown little interest in exploring the world around them when they initially entered the experimental room. Securely attached infants are considered the best attachment category in terms of psychological health, while avoidant children sometimes may have positive and sometimes negative outcomes.

Main and Solomon (1990) proposed the addition of a fourth category of attachment between an infant and its caregiver, the disorganized attachment pattern, as the three-category system had remained largely unchallenged over several years. Main and Solomon's disorganized pattern described a pattern of inconsistent and unpredictable attachment behaviour of children in various situations.

Research has shown that it is advantageous for a child to have a secure attachment pattern (Arend, Gove, & Sroufe, 1979). Children who show a secure pattern are more flexible, less egoistic, and establish better peer relationships than insecure children (Waters, Wippman, & Sroufe, 1979). They are imaginative, disciplined and responsible towards their parents and manage difficult situations well, showing limited frustration (Ainsworth et al., 1978; Matas, Arend, & Sroufe, 1978). Moreover, securely attached children show confidence and fluency while talking to their mothers and are more open in their emotions and feelings when they reach the age of six (Main, Kaplan, & Cassidy, 1985).

Securely attached infants approach confidently the attachment figure on reunions and are more intimate and emotionally closed and remain close in times of stress (De Wolff & van Ijzendoorn, 1997). They show more excitement in exploring activities and are more open in sharing their feelings (Main, Kaplan, &

Cassidy, 1985). They can overcome their frustration and remain calm and confident in hard times (Ainsworth, 1978). Those children have caregivers who are always there to support them physically and emotionally, are certain about their relationships, and systematically develop feelings and behaviours towards a secure attachment bond (Schore, 2001). Securely attached children explore the world confidently and independently under caregivers' protection and availability in need (Ainsworth et al., 1978; Bowlby, 1988).

In contrast, children showing an insecure attachment style in the Strange Situation presented poor adjustment in various domains when they reached the age of two and had difficulty in controlling negative emotions (Matas, Arend, & Sroufe, 1978; Sroufe, Carlson, Levy, & Egeland, 1999). Carlson (1998) found that psychological and social dissociation at ages 17–19 was linked to attachment disorganization at ages between 24 and 42 months. Furthermore, infants with an anxious or resistant attachment pattern towards the primary caregiver suffer from a variety of anxiety disorders in adolescence (Warren, Huston, Egeland, & Sroufe, 1997) while infants showing avoidant attachment present conduct problems and other childhood disorders in later ages (Aguilar, Sroufe, Egeland, & Carlson, 2000).

Insecure infants have poor adaptive qualities (Matas, Arend, & Sroufe, 1978). They are not able enough to control negative feelings and become helpless in a distressing situation (Sroufe, Carlson, Levy, & Egeland, 1999). Resistant attachment in infant–mother relationships leads to anxiety later in life (Warren, Huston, Egeland, & Sroufe, 1997). Children develop an insecure attachment pattern when the caregiver shows no response or is only occasionally available to manage their stress and anxiety (Ainsworth, 1978; De Wolff & van Ijzendoorn, 1997). Such children will respectively develop either an insecure-avoidant or an insecure-anxious/ambivalent attachment pattern towards their caregiver

(Ainsworth, 1978). Every attachment style is based on both caregiver's and child's responses (Ainsworth, 1978; Main & Solomon, 1990).

Ambivalent children are anxious about their surroundings and disinclined to distance themselves from the primary caregiver in new circumstances (Kennedy & Kennedy, 2004). They tend to develop a negative internal working mode of self and others and resistance and denial towards their caregiver as their attachment figure is mostly unavailable to their need for safety (Ainsworth & Bell, 1970: Riggs, 2010). These children are also likely to develop an emotional disorder. On the other hand, avoidant children do not trust their attachment figure and remain independent (Bartholomew, 1990) as the result of continuous rejection and lack of support (Riggs, 2010). They stay emotionally and physically distant and do not trust any support at a time of stress while they often misbehave, e.g. they lie or bully other children (Kennedy & Kennedy, 2004).

Disorganised children are very confused and fearful and tend to develop a negative mode of self and others (Riggs, 2010). They are emotionally irregular as a result of the unavailability and hostility of the attachment figure and often develop problem behaviours including violence, enmity, emotional overcontrol, and behavioural abandonment (Kennedy & Kennedy, 2004). Children develop the disorganized attachment pattern as they both long for or fear to get close to caregiver and as a result they behave ambiguously (Main & Solomon, 1990). Moreover, disorganised children express unsystematic competencies as they interrupt work to follow up their attachment needs. The literature relates the child–caregiver relationship to forthcoming relationships (Bowlby, 1969, 1980; Parkes, 2006; Stroebe, Schut, & Stroebe, 2005).

Authors argue that a child may show different attachment patterns to different caregivers or on different occasions, but one style is more prominent overall

(Cowan & Cowan, 2007). Nonetheless, studies have shown that about 62% of infants continue to have the same attachment relationship to their primary caregiver at 12 and 18 months (Vaughn, Egeland, & Sroufe, 1979) and others report similar findings with regards to the ages of 4 and 6 years (O'Connor & Rutter, 2000). According to Kobak, Rosenthal, and Serwick (2005), most western-cultured children have one attachment pattern that continues throughout life. Parent–child attachment plays a vital role in children's later life. It affects a child's social and psychological development, especially the emotional and cognitive development related to interpersonal relationships (Thompson, 1999).

Although the Strange Situation procedure has dominated childhood attachment research, a number of other measures have also been developed aiming to address some of the limitations of the Strange Situation. Those limitations included mainly its reliance on behaviour as opposed to representation and its unsuitability in research with older children and adolescents. Alternative measures include the Story Stem Assessment Profile (Hodges, Hillman, Steele, & Stufkens, 2015), the Attachment Doll Play Assessment (George & Solomon, 1990–2016), the Manchester Child Attachment Story Task (Green et al., 2000), the Preschool Assessment of Attachment (Crittenden, 1992), Disturbances of Attachment Interview (Smyke & Zeanah, 1999), and the Adult Attachment Projective Picture System (George & West, 1999).

Two adaptations of the AAI have also been created: the Child Attachment Interview (Farnfield, 2014; Target et al., 2003) for children and the Attachment Interview for Childhood and Adolescence. Finally, a number of self-report questionnaires for older children and adolescents have also been created, such as the Security Scale (Kerns et al., 1996) or the Coping Strategies Questionnaire (Finnegan, Hodges, & Perry, 1996).

A number of studies suggest that insecurely attached children have emotional and behavioural problems more often than secure children and that the quality of attachment in early childhood might have a significant impact on socio-emotional development and mental health in later life (Lamb, Thompson, Gardner, Charnov, & Estes, 1984; Rutter, 1995).

Jacobsen and Hofmann (1997) found that school children with insecure working models of attachment at the age of 7 were less confident and had greater academic difficulties than secure children at ages 9, 12, and 15.Other studies suggest that insecure school children more often display shyness, hostility towards other children, and dependency (Calkins and Fox, 1992; Lyons-Ruth et al., 1993; Sroufe et al., 1993). Insecurely attached children are more vulnerable to negative feedback and feel more pressurised by peers (Barnett & Butler, 1999), which decreases further their self-confidence and may lead to clinical anxiety and depression (Thompson, 2000). Insecure attachment also predisposes to depression, anxiety and other negative emotional reactions when a child faces a new social experience, due to the excessive stress the individual experiences (Waters & Cummings, 2000).

Several factors relating to internal working model of attachment mediate the link between life stressors and mental health problems, including the capacity to experience comfort and support consistently and explore the environment (Goldberg, 1997), expecting positivity rather than hostility from social relations (Dodge & Coie, 1987), idealizing the caregiver as a model of prosocial behaviour (Guttmann-Steinmetz, & Crowell, 2006), receiving continuous parental care and responsiveness (Lamb et al., 1984), and being effective in emotion regulation (Cassidy, 1994).

In a longitudinal study, Erickson, Sroufe, and Egeland (1985) asked observers to

assess different young children's behaviours including social competence, ego control, peer confidence, and externalizing behaviour problems. The findings showed that secure children scored worse than insecure children on these behaviours. However, earlier research findings on the link between attachment insecurity and externalizing problems were unclear. Bates, Maslin, and Frankel (1985) reported no association between attachment security at 12 months and parental reports of externalizing behaviour at age 3, and similar mixed findings were also reported in other studies in the 1980s and early 1990s (e.g. Belsky & Nezworski, 1988). Also, in another study, attachment insecurity was associated with externalizing problems among boys rather than girls (Renken et al., 1989).

However, the discovery of the disorganised pattern (Main & Solomon, 1986; 1990) gave a new research direction. Since then, several studies have found that the disorganised attachment pattern may be a stronger predictor of child behavioural problems than the other insecure patterns, for example, in relation to aggression, as awareness of a child's problem behaviour may be compromised by lack of emotional regulation and dissociative processes (Fonagy, 2004; Liotti, 1992; Solomon & George, 1999).

While a large longitudinal study with over one thousand participants did not find greater externalizing behaviour problems among disorganized children (Belsky & Fearon, 2002; NICHD Early Child Care Research Network, 2006), two meta-analytic studies did. A meta-analysis of 12 studies showed a strong association between disorganized attachment and an increased risk for externalizing behaviour and aggression (van Ijzendoorn, Schuengel, & Bakermans-Kranenburg, 1999) and so did a more recent meta-analysis (Fearon, Bakermans-Kranenburg, van Ijzendoorn, Lapsley, & Roisman, 2010). Fearon and colleagues analysed 69 samples (N = 5947), to find that the effects of insecure and disorganized attachment styles increased the chances of externalizing problems occurring.

Higher effects were found in boys, clinical samples, and in studies using observation-based outcome assessments and assessments other than the Strange Situation.

Meta-analytic studies have also suggested a link between insecure attachment and internalizing behavioural problems as well as difficult peer relationships (Madigan, Atkinson, Laurin, & Benoit, 2013; Pallini, Baiocco, Schneider, Madigan, & Atkinson, 2014).

Children with special needs have a particular vulnerability to emotional and behavioural difficulties. Having a child with special needs can be very challenging for parents who may struggle with feelings of guilt, grief, responsibility, denial, shock, trauma, anger, and shame (Vacca, 2006). Such parental experience may have a negative impact on the parent–child relationship. Studies show that children with autism and Down's syndrome have greater difficulty establishing a secure attachment with their parents (Bakermans-Kranenburg et al., 2003; Barnett et al., 1999), while a poor bond between parent and blind child may predispose to further later impairment in the socialization of the child (Vincent & Hasselt, 1983).

The impact of insecure attachment on psychopathology extends beyond childhood as a very large number of psychiatric patients report negative attachment experiences including loss, abuse, neglect, and conflict (Goldberg, 2000). As the bond with the parent is essential in a child's life, the failure of the attachment figure to provide safe haven and a source of comfort in times of need creates a significant vulnerability in the individual.

Attachment in adulthood

Furthermore, attachment research has advanced significantly in relation to adult

attachment as well. Child attachment patterns have been significant for the study of adult attachment, as they are often the predecessors of adult attachment patterns. Adult attachment has been measured by a range of interview and questionnaire measures among which the Adult Attachment Interview (AAI; George et al., 1985) is of major significance. The AAI is semi-structured, based on 20 questions that assess *state of mind* in relation to attachment. Interviewees are asked to speak about childhood experiences and the relationship with their parents as well as current relationships. They are asked to describe the relationship with parents using five adjectives and then to justify their answers with specific examples.

The method focuses on the coherence of the interviewees' accounts rather than their content, particularly in relation to separation from parents, feelings of rejection, experiences of loss, and perceived influences of childhood experience on adulthood. Coherence is assessed based on Grice's (1975) maxims of communication competence including quality, quantity, relation, and manner. Competent communication includes narratives that are logically and clearly sequenced and interconnected. Such narratives are believable and logical, with enough but not too much detail, the information provided is relevant, clearly, and transparently communicated. Research on AAI suggests that securely attached individuals generate coherent accounts while insecure individuals violate Grice's maxims in their accounts (Hesse, 1996).

AAI classifications are similar to those of the Strange Situation classifications for infants (Ainsworth et al., 1978), including a secure or Autonomous state of mind, a Dismissing pattern characterised by attachment avoidance, a Preoccupied pattern characterised by attachment anxiety, and an Unresolved pattern characterised by attachment disorganisation (Main & Goldwyn, 1991). Dismissing individuals find it hard to recall and give a coherent account of painful events

such as parental rejection, often contradicting themselves. They also tend to idealize parents and report lack of memory. Preoccupied individuals tend to report anger in current relationships, and present confused, long, and entangled accounts of the past attachment experience. Finally, unresolved individuals generate highly incoherent, fragmented, and implausible narratives, often referring to experiences of significant loss, fear, and trauma.

Research suggests a high level of correspondence between a parents' attachment classification in the AAI and their infants' attachment pattern in the Strange Situation. Autonomous mothers tend to have secure infants, dismissing mothers insecure-avoidant infants, preoccupied mothers insecure-ambivalent infants, and unresolved mothers disorganized infants (Fonagy, Steele, & Steele, 1991; Main et al., 1985 ; Main & Goldwyn, 1992 ; van Ijzendoorn, Kranenburg, Zwart-Woudstra, Van Busschbach, & Lambermon, 1991).

Several studies have provided support for the reliability of the AAI (Bakermans-Kranenburg & van Ijzendoorn, 1993; Sagi, van Ijzendoorn, Scharf, Koren-Karie, Joels, & Mayseless, 1994) and its discriminant validity against measures of intelligence, memory, cognitive complexity, social desirability, and social adjustment (Bakermans-Kranenburg & van Ijzendoorn, 1993; Sagi et al., 1994). Studies referred to above support the method's predictive validity against the Strange Situation (Fonagy, Steele, & Steele, 1991). The AAI has been a major development in attachment research, having two significant advantages: it combines qualitative and quantitative methodology and is not very susceptible to distortions of the content of accounts. On the other hand, it requires extensive training, and considerable time and financial resources.

The AAI inspired the development of the Current Relationship Interview (CRI), an interview following the same focus on narrative coherence as a marker of

security but addressing current couple relationships (Crowell & Owens, 1996; Crowell, Treboux, & Waters, 2002). The scoring of CRI is similar to that of the AAI, assessing interviewees' experience with their current partner, the behaviour of the participant, the behaviour of the partner, and the narrating style, coherence, and plausibility of the participant's narrative. CRI classifications are also similar to those of the AAI: Secure, Insecure-Dismissing, and Insecure-Preoccupied.

Individuals who are securely attached to their partners report relationships of mutual understanding and support with their partners in way that general relationship statements are supported by specific instances. On the other hand, insecurely attached partners generate accounts with evident contradictions: the partner's positive attributes may be reported but there is also evidence for longing for support and closeness (Crowell et al., 2003). Research reports significant links between CRI and AAI classifications providing evidence of attachment continuity across different relationship domains (Treboux, Judith, Crowell, & Waters, 2004). Like AAI, CRI has the advantage of relying on narrative coherence rather than content, plus it focuses on a current relationship. However, it may not assess more generic working models based on the parent–child relationship and it still requires significant time and resources.

Another approach to adult attachment used in the mental health field has been developed by Bifulco and colleagues (Bifulco et al., 2002a, b). The Attachment Style Interview (ASI) is a semi-structured interview assessing an adult's capacity to utilise support from their close relationships. It is based on open questions as well as questions aiming to extract more descriptive content and information on behaviour (e.g. 'Can you describe a recent problem that you confided in your partner?' 'How often do you have arguments or rows?'). Questions focus on emotional closeness, distance, and independence in relationships as well as emotions such as anger and fear of rejection/separation. The first part of the

interview captures the quality of support from one's partner and other close relationships while the second part assesses the capacity of the individual to carry on with particular relationships on the basis of the support provided.

Eight subscales are used to assess the different relationship dimensions (mistrust, constraints on closeness, self-reliance; anger, desire for engagement with others, intolerance of separation, fear of intimacy) and also an overall measure of security is used. The ASI identifies five overall attachment styles: Enmeshed, Fearful, Angry Dismissive, Withdrawn, and Secure, and three intensity grades: mildly, moderately, and markedly insecure. The measure has good reliability (Bifulco et al., 2002a; Yoshida et al., 2004) and has been associated with depression in women's quality of parent–child relationships, and quality of emotional support from the partner (Bifulco et al., 2002a, 2006a). The Fearful and Angry Dismissive styles have been found to mediate the association between childhood neglect and abuse with clinical depression and anxiety in later life (Bifulco et al., 2006b).

Bifulco and colleagues have also developed a questionnaire-based measure on similar principles – the Vulnerable Attachment Style Questionnaire (Bifulco, Mahon, Kwon, Moran, & Jacobs, 2003). Like the AAI, the ASI provides depth of information, but requires significant time and cost to be administered as appropriate.

Other important approaches to adult attachment come from social psychologists and are based more on content of discourse and less on coherence. These involve three- and four-category measures, reflect Bowlby's (1977) theoretical formulations, and stem from Ainsworth's (1978) assessments of infant behaviour in the Strange Situation. A number of studies have supported Ainsworth's attachment classification indicating that early attachment patterns may have an

impact on attachment-related behaviour later in life.

Hazan and Shaver (1987) applied attachment theory to the study of adult romantic relationships and proposed that romantic relationships can be categorised in a way similar to Ainsworth's (1978) three-category attachment model. Securely attached adults are comfortable with closeness and dependency in their romantic relationships while valuing their own identity. They find it relatively easy to get close to others and are comfortable depending on others and having others depend on them – they can be interdependent and comfortably intimate with their romantic partners. Secure attachment allows individuals to express distress and receive comfort and support from others (Kennedy-Moore & Watson, 1999). Not surprisingly, the secure attachment style is associated with the most satisfaction with respect to interpersonal relationships and with the highest levels of psychological well-being (Collins & Read, 1990).

On the other hand, avoidant adults (dismissing) are afraid of an increase in closeness and prefer to be independent from their romantic partner or other close relationships. Moreover, adults with an anxious attachment style show preoccupation with their close and romantic relationships and wish to be closer and more dependent on their partners. They also express strong and variable emotions and communicate distress in a heightened way (Kennedy-Moore & Watson, 1999).

According to Bowlby (1988), children's attachment patterns are internalized in the form of internal working models of self and others and those models will be used at later lifestages to meet attachment needs. Internal working models develop and may or may not change with time as children grow up, blending past and present experiences of self and others. Secure children are more open and

flexible in reshaping their internal working models, as they tend to be confident and willing to explore the word. On the other hand, insecure children are stiff and inflexible in their developing of their working models because of their initial negative experience (Bowlby, 1988). Attachment research suggests that children and adults meet their attachment needs on the basis of their past experiences as well as of the present situation. Hazan and Shaver (1987) utilised the concept of working models proposing that adult romantic relationships are based on individuals' attachment styles.

Bartholomew (1990) extended Hazan and Shaver's classification into four attachment styles, utilising the concept of internal working model of self and significant other arriving at four attachment styles: *secured, dismissing, preoccupied,* and *fearful.* Individuals with a fearful avoidant attachment style are afraid that they will be abandoned or hurt while individuals with a dismissing avoidant attachment styles feel more independent and self-sufficient. Thus both try to avoid the attachment figure.

Bartholomew and Horowitz (1991) proposed that internal working models consist of two parts: one that deals with thoughts and feelings about the self and another that deals with thoughts and feelings about others. According to the authors' model, individuals with a secure attachment style present a positive internal working model of self and a positive working model of the significant other.

Table 1.1

Internal Working Model (Bartholomew & Horowitz, 1991)

	Positive Others	
Positive Self	**SECURE**	**PREOCCUPIED**
	DISMISSING	**FEARFUL**
	Negative Others	

Negative Self

However, individuals with a preoccupied attachment style present a negative internal working model of self and a positive internal working model of significant others, while dismissingly avoidant individuals present a positive internal model of the self and a negative internal model of the significant other. Finally, fearful or fearful avoidant adults are informed by a negative internal working model of both the self and the significant other.

Fearful adults often have disorganized relationships. On the one hand, they want intimacy but on the other they feel uncomfortable with emotional closeness as they fear rejection and find it difficult to trust or let themselves depend on others. This is contrary to the dismissing group, who are more comfortable without close relationships. Research has also shown that individuals with a fearful or disorganised attachment style are at particular risk for psychopathology and has linked this attachment style to adult violence, trauma, and maltreatment (Lyons-Ruth & Jacobvitz, 1999).

It was Bartholomew (1990) who first utilised attachment dimensions developing further the categorical concept of attachment styles. Research has shown that attachment dimensions may have greater accuracy and validity than a system

based on attachment categories.

Table 1.2

Attachment Styles Development over time

Child-Primary Caregiver Attachment Styles		**Adult Attachment Styles**	
Ainsworth (1978)	Main & Solomon (1990)	Hazan & Shaver (1987)	Bartholomew (1990)
Secure	Disorganized-Insecure	Secure	Secure
Anxious-Ambivalent		Anxious	Preoccupied
		Ambivalent	Dismissing
Avoidant			
		Avoidant	Fearful

Bartholomew and colleagues have utilised both questionnaire and interview measures to assess the four attachment styles they propose (Bartholomew & Horowitz, 1991). Their Attachment Interview (AI) asks interviewees to describe their friendships, romantic relationships, and how they feel about the importance of close relationships. If any participants had no romantic relationships, they were asked to explain why, but questions regarding loneliness and shyness, how much they trust of others, how they think of their impressions of other people's evaluations of themselves, and to what extent they are hopeful for any improvements in their relationships are asked of all participants as appropriate.

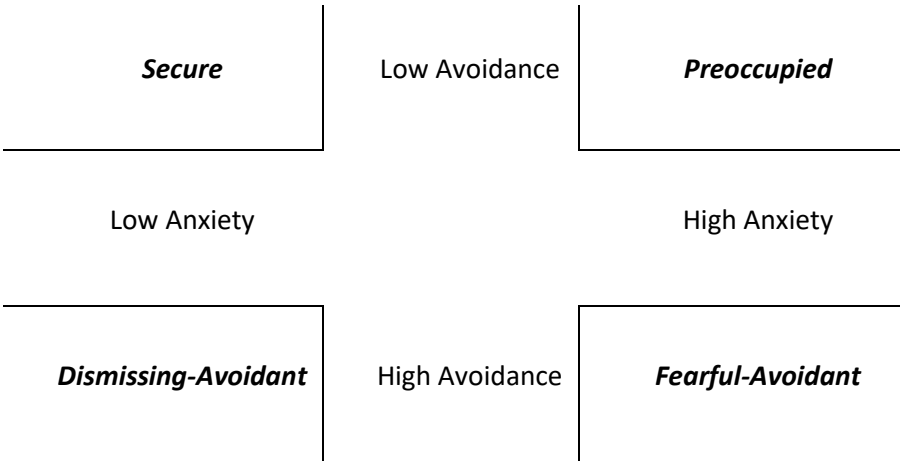
Interview material is rated usually by three independent raters, on four 9-point scales, each corresponding to one of the four attachment styles. Individuals are judged as secure if they value intimate relationships, are able to maintain them,

and show coherence and thoughtfulness in their discourse. They are judged as dismissing if they avoid discussing the importance of close relationships, if they are emotionally restricted and talk more of independence and self-reliance, and if they show limited commitment to relationships. Individuals are judged as preoccupied when they are over-involved in and dependent on close relationships, are incoherent and excessively emotional when discussing relationships. Lastly, individuals are judged as fearful when they avoid relationships, fear rejection, and distrust others. The rating scales of the AI have shown good reliability and validity against self-rated measures of attachment, self-concept, sociability, interpersonal problems as well as friend reports (Bartholomew & Horowitz, 1991).

Adult attachment styles have also been categorised on the basis of two dimensions: attachment avoidance and attachment anxiety (Brennan, Clark, & Shaver, 1998). Individuals with a low score in both anxiety and avoidance present with a secure attachment style while those with a high score in attachment anxiety and a low score in attachment avoidance present with a preoccupied attachment style. On the other hand, a high score in avoidance and a low score in anxiety indicates a dismissing attachment style, while a high score in both anxiety and avoidance indicates a fearful attachment style (see Table 1.3).

Table 1.3

Four Adult Attachment Styles (Bartholomew & Horowitz, 1991)



Brennan, Clark, and Shaver (1998) found in their research while using the Experiences in Close Relationships scale (ECR) that two-dimensional attachment styles are well-matched with Bartholomew's conceptual scheme of self and other in Bartholomew (1990) and Bartholomew and Horowitz (1991). "Attachment related anxiety" and "attachment related avoidance" were the names of two attachment dimensions given by Brenan, Clark, and Shaver (1998). Attachment-related anxiety involves anxiety related to neglect, rejection, deprivation in affection, and attachment-related avoidance involves avoidance in close relationships and being dependent. Modern studies (Fraley & Shaver, 2000) have supported this two-dimensional representation of adult attachment style. Further recent research even has supported infant attachment to parents or primary caregivers (Fraley & Spieker, 2003).

Attachment styles in adulthood are widely studied. Adult attachment differences have an impact on all types of social relationships especially in adult romantic relationships and they are related to working models based on self and social

relationships (Collins & Read, 1990). Individuals may sometimes not be aware of their feelings as they may push feelings away non-consciously as a defence to prevent further anxiety. For example, avoidant individuals may think they are not scared to lose someone while they are or preoccupied individuals may not be able tell us that they feel lonely and why as this may be too stressful for them to bear. On the other hand, secure individuals usually can explain their negative emotions. Investigators study the stability of working models by looking at the stability of attachment styles. Attachment styles reflect the thoughts and expectations that constitute working models. Attachment working models may function as inner structures upon which people organize experience and handle distress (Bowlby, 1973, 1988).

Research links attachment style to psychological distress as adults with an insecure attachment style are more likely to suffer from depression and anxiety (Buelow, McClain, & McIntosh, 1996). Anxiously and fearfully attached adults are at greater risk for developing such a psychological disorder compared to the secure and the dismissing, while adults with an anxious or preoccupied attachment style present more often with post-traumatic disorder (Mikulincer, Horesh, Eilati, & Kotler, 1999). Additionally, research shows that personality disorder is also associated with adult attachment style, as individuals with fearful or preoccupied attachment styles present more often with such disorders compared to adults with a secure attachment style (Brennan & Shaver, 1998). Finally, adults with an avoidant attachment style report greater psychological imbalance compared to adults with a secure style (Maunder, Lancee, Nolan, Hunter, & Tannenbaum, 2006).

Adults' attachment styles also predict their coping style during stress. Research indicates that compared to the insecurely attached adults, securely attached adults find social support more easily to utilise as a coping mechanism while in

distress. On the other hand, insecurely attached adults tend to experience difficulties in finding social support (Schmidt, Nachtigall, Wuethrich-Martone, & Strauss, 2002). Securely and avoidantly attached adults can easily divert their focus from the distressing events and positively move towards coping while ambivalent adults are more negative in their thinking about the distressing event and show negative emotional coping (Schmidt et al., 2002).

For infants and children the primary caregivers are the parents or any other figure with parental responsibilities, e.g. a worker in daycare (De Schipper, Stolk, & Schuengel, 2006) or a teacher (Cugmas, 2007), while adolescents develop some attachment to their peers or other family members or family friends (Doherty & Feeney, 2004; Hazan & Shaver, 1987). Couple partners play the most important role as attachment figures in adulthood as adults turn to them in times of distress (Doherty & Feeney, 2004).

However, adults are more likely to make a choice of which attachment relationship to utilise in a time of need. Research shows that adults seek support from family members, utilising them as a secure base, while they may also turn to friends in seeking daily support (Doherty & Feeney, 2004). In addition, older parents often turn towards their adult children for support rather than turning towards friends. All close relationships in adulthood including romantic partners, friends, parents, and other family members can play the role of an attachment figure.

A very important consequence of insecure adult attachment, particularly among parents, is the impact that it has on offspring attachment security and mental health. Research has indicated that the quality of attachment mothers experienced with their own parents were associated with the attachment they developed with their own children (Fonagy, Steele, & Steele, 1991; Main &

Solomon, 1990). These studies suggest that adult attachment classifications in the AAI and infant attachment classifications in the Strange Situation show a significant association. Mothers classified as Autonomous in the AAI tend to have children classified as Secure in the Strange Situation, while Dismissing mothers tend to have Avoidant children, preoccupied mothers tend to have Anxious children, and unresolved mothers tend to have Disorganised children. A recent longitudinal study has found that the mother's AAI classification during pregnancy predicted important markers of security in their children 17 years later (Steele, Perez, Segal, & Steele, 2016).

A critical factor behind these associations is parental sensitive responsiveness, as Autonomous adults tend to respond in a more sensitive way to their children's signals. On the other hand, Dismissing parents tend to underrespond to the child's attachment behaviours, preoccupied parents tend to be unreliable, while unresolved parents are often frightening or abusive to their children. These studies suggest that parental sensitivity to their child's attachment needs shapes the child's own internal working model of attachment (De Wolff & van Ijzendoorn, 1997; Main & Goldwyn, 1992).

These findings are consistent with older research on the role of parental sensitivity suggesting that children of insensitive mothers are socially inhibited, which leads to peer problems and predicts future social problems (Rubin, 1988), and that abusive and neglectful mothers are less sensitive than non-abusive and non-neglectful mothers (Crittenden, 1981; de Zulueta, 2006). This is also consistent with studies suggesting the intergenerational transmission of attachment-related problematic behaviour like abuse, as abused children are more likely than non-abused to become abusive parents themselves (Belsky, 1993).

Parental insensitivity and child insecure attachment predispose the child to ineffective coping and unsupportive relationships, which lead to behavioural problems (Cummings & Cummings, 2002; Sroufe, Carlson, Levy, & Egeland, 2003). Maternal narrative coherence in the AAI has been related to parenting behaviour, as reflective caregivers tend to be securely attached themselves and more responsive to the needs of their children (Fonagy, Steele, Steele, Moran, & Higgitt, 1991). Insecurely attached parents are unable to mentalise – that is, to accurately understand the mental states of self and other, including those of their children (Fonagy & Campbell, 2016).

Insecurely attached adults are more likely than secure adults to suffer from psychological disorders themselves and their children (Beesley & Stoltenberg, 2002; Whiffen, Kerr, & Kallos-Lilly, 2005). Recent research suggests that the quality of the couple attachment plays also an important role in children's outcomes. The authors argue that individual parental attachment pattern together with couple attachment predict future attachment status, academic competence, and externalizing and internalizing behaviour in the child (Cowan, Cowan, & Mehta, 2009). Studies show that attachment disorganisation in the parent may have the most detrimental effects on parenting ability, couple relationships, and child mental health, as it is linked with trauma, abuse, and unresolved grief (Main & Hesse, 1990; Yellin & White, 2012).

Attachment and bereavement

Death and bereavement are experiences of great significance for both children and adults. Grief is a condition in which a person experiences the loss of someone very important and like any other source of major stress, the experience of loss activates attachment behaviour (Barbato & Irwin, 1992). The concept of attachment has contributed to our ability to understand grief as it

attempts to understand the interpersonal relationships involved and their impact on reactions to bereavement (Stroebe & Schut, 2005). Attachment theory explains that a grieved child shows similar behaviour to a substantial death loss as they do when they are separated from their mother or primary caregiver. That response includes protest, despair, and later detachment and lack of interest (Bowlby, 1980).

John Bowlby proposed that in the grief process adults behave in a way similar to children who have been separated from their mother for extended periods of time. In those circumstances children think of that as a permanent separation. Bowlby found that adults show the same behaviour towards the death of a loved one as the hospitalized children he studied in his research. For example, adults feel longing for the deceased, keep denying the loss, and criticise themselves (Bowlby, 1980). The attachment relationship between a primary caregiver and a child indirectly affect the child's understanding and coping of death. It depends on the quality of attachment relationship and a sense of security they feel in that relationship.

Bereavement research has been strongly associated with attachment theory (Stroebe, 2002). Bowlby (1973, 1980) proposed parent-child attachment starts in infancy when the child requires safety and satisfaction. They form a bond between tehmselves and the caregiver to fulfil their needs and to provide a safe haven in trials and distress. Bowlby, in his trilogy, suggests that people's reactions to bereavement develop from attachment systems that have become organized with their development. In the literature, the quality of the parent–child relationship is regarded as an important factor in determining the predisposition of the child towards anxiety and a mature understanding of death.

Attachment theory claims that the attachment relationship between a child and

a primary caregiver is the basis for children and adults' understanding and reacting to death. The child's attachment pattern will have a lifelong effect on the adult's attachment style and experience with bereavement as both children and adults react to loss and try to re-establish their attachment relationships after facing death of their loved ones (Stroebe & Schut, 2005).

Research indicates that attachment patterns in childhood can predict bereavement style in adulthood (Walter, 1994). As the childhood attachment pattern will have a lifelong effect on an adult's attachment style it may also affect in similar ways experience with bereavement in both children and adults, how they react to loss, and try to re-establish their attachment relationships after facing the death of a loved one (Stroebe & Schut, 2005).

Attachment and bereavement in childhood

Previous attachment and bereavement studies have argued that the quality of the parent–child relationship is closely associated with the child's anxiety during the grieving process and its maturity to understand death and loss (Bowlby, 1969; Stroebe & Schut, 2005). Normally, infants respond to separations from the primary caregiver by protesting briskly and crying loudly. If their cries are not responded to and they are unable to restore proximity with the attachment figure, they develop despair and finally, show lack of interest and detachment. Infants show similar separation anxiety in temporary short-term separations as they do in long-term separations (Bowlby, 1969). As they perceive long-term or permanent separation to be the same as death, they have little understanding of death and react to it in ways similar to how they react to separating from the primary caregiver.

Studies show that when infants and toddlers react to the death of a parent, their mourning style is different from that of adults and older children (Furman, 1974).

Their reactions include more physical symptoms, such as feeding problems, wetting the bed and clothes, stomach pains, and difficulties in sleeping. With age, children develop their cognition towards loss and separation so that they can understand the difference between temporary and short-term departures of the caregiver and permanent ones like death. They may understand different aspects of death such as irreversibility and universality of death, causality of death, and permanency of death. They may even understand the differences between a dead and a living person such as that the dead are different in terms of mobility and the capacity to feel, hear, smell, or speak; they understand that the dead lack all these functions. However, understanding of the changes regarding the appearance of the dead, are not clear to children before they reach their adolescence. According to attachment theory, as grief is normal, reactions such as yearning and anxiety are also considered to be normal, as are the child's attempts to be reunited with the deceased (Shaver & Tancredy, 2001).

Attachment theory suggests that normally a child's reaction to bereavement is very predictable. According to Bowlby (1960), a secure base in an attachment relationship provides confidence to the child to face the loss and overcome withdrawal and disinterest in daily activities. On the other hand, a child who has no secure base would remain isolated from the world during the grieving process. That would be an understandable reaction, a reflection of the attachment relationship that the child has with the caregiver (Scott, 2004).

Research shows that the attachment relationship between the child and the primary caregiver is the basis for children's and adults' understanding and reacting to death. Bowlby reported that an insecure parent–child attachment pattern involves the distraction of the child's attention in new situations and the misunderstanding of their mother's intensions. This gave a strong base to current bereavement research.

As Bowlby focussed on depressed children and Parkes (1996) on bereaved individuals and the loss of important relationships in life, research by Ainsworth et al. (1978), Main and Solomon (1986), and Shaver and Tancredy (2001) contributed to the understanding of individual differences in attachment, bereavement and grieving process. Secure and insecure attachment patterns in early childhood relationships continue over time and affect the formation and dissolution of future relationships. Child attachment patterns can predict the bereavement process and how a child will adapt to the experience. Insecurely attached children have difficulty in dealing with negative emotions and are often unable to get support in the grieving process (Sroufe, Carlson, Levy, & Egeland, 1999). Anxious and disorganised children are fearful in parental absence and so they may face even mental disorder and serious coping difficulties when they experience the irreversible death of a loved one. On the other hand, children with an avoidant attachment style rooted in their parents' continuous under-responsiveness delay their acceptance of eternal loss and they also may face serious difficulties in adjustment.

Attachment theory states that the relationship between a child and the primary caregiver greatly affects how children understand and respond to loss, how they focus, how they are aware of their emotions, how they manage their feelings, how they face the trials and tribulations, and how they form their future relationships (Bretherton & Munholland, 1999). Research reveals that the attachment bond shapes an infant's brain (Segal & Jaffe, 2012).

According to Bowlby and the attachment literature, the quality of the parent–child relationship is the pathway in shaping the tendency of the child towards anxiety and the development of a mature understanding of death. The parent's attachment style works as a potential mediator between bereaved children and their environment. Research shows that emotional regulation in children is

influenced by the way parents deal with their own emotions (Fonagy et al., 2002). Parental attachment style influences the quality of parenting provided and the capacity of the child to deal with negative experiences and emotions. Research also suggests that grief reactions are intergenerationally transmitted (Gajdos, 2002). A main aim of the present study is to investigate how this intergenerational transmission occurs.

Research suggests that avoidant parents show little emotional closeness to their children and think negatively about them (Rholes, Simpson, & Blakely, 1995; Rholes, Simpson, Blakely, Lanigan, & Allen, 1997). As a result, the children become more hostile and distant and may also develop negative views of their parents (Kerr & Stattin, 2000). On the other hand, anxious parents are invasive and hindered in their attachment style (Collins et al., 2006). As they are more occupied with other intimate relationships and are fearful and worried about being abandoned (Shaver & Mikulincer, 2002), it is likely that their children will be neglected and therefore exhibit negative, even disturbing behaviour.

When the primary caregiver can manage personal stress, calm the infant, communicate through emotion, share joy, and forgive easily, the young child's nervous system is more able to deal with loss. Our attachment bonds shape our abilities to feel safe, develop meaningful connections with others, explore our world, balance emotions, experience comfort and security, deal with stress, loss, and death, and make sense of our lives and create positive memories and expectations of relationships (Segal & Jaffe, 2012).

A variety of behavioural problems in children may come as the result of their response to the death of a loved one. Children who encounter the death of a parent go through a very hard and stressful time and they may be affected by additional, difficult psychological and social circumstances that continue in their

lives. Often bereaved children have behavioural problems less likely to be encountered among non-bereaved children (Auman, 2007). Parents and family members cannot stop death and loss; however, they can develop secure attachment relationships and support the bereaved children.

In a similar way to adults who experience different types of illusion in relation to the deceased, children may also experience false perceptions they take as real, as, for example, they may think that their parents are alive again or have visions of a visiting ghost of the parent. The limited cognitive capacity of the child can cause many anxieties around death. As children are in need of a parent or other primary caregiver, when one parent dies the child may become sensitive and anxious about the surviving parent and try to hide the grieving and mourning from that parent in order to protect them from depression and anxiety. When they begin to become calmer, the surviving parent or other carers take it as a sign of the child's recovery from the grieving process and the bereavement experience.

If the parent–child relationship develops in a positive way the child's emotional security develops, while if parent–child bonding breaks down due to parental death, ill health, or other family problems, the child is likely to develop emotional difficulties (Bowlby, 1944). Bowlby (1980) reported that children's reaction to temporary separation from their primary caregiver for an extended time duration is similar to how adults experience and react to loss and grief. It seems that children think and behave as if the temporary loss were a permanent one. Bowlby noted how many times they call for their mothers and how they showed longing for their primary caregiver in symbolic play.

It seemed strange that after reuniting with their primary caregiver whom they were so eager to meet and longed for, they showed disinterested and behaved

indifferently, such as they tried to hide their pain and feelings when they were hurt and even they did not allow their primary care taker to try to give them relief and comfort (Bowlby, 1980). Further, he observed that hospitalized children showed the same behaviour and reaction to the experience of bereavement, caused by the death of attachment figure. Adults react similarly to permanent loss. They long for the deceased, deny the irreversibility of the death, blame themselves for the loss, and try to behave as caregiver while responding to the loss (Bowlby's 1980). Bowlby's and Ainsworth's attachment theory (Ainsworth & Bowlby, 1991; Bowlby, 1969) is extended to adult attachment theory (Fraley & Shaver, 2000; Hazan & Shaver, 1987) that attempts to explain feelings, understandings, and reactions of adults to the loss of a loved one.

Attachment and bereavement in adulthood

Adult attachment theory proposes that attachment styles in adults develop from their childhood attachment relationships to their primary caregivers. According to Mikulincer and Shaver (2003), attachment styles are linked to many important variables, for example, the psychological impact of intimate relationships, behavioural changes towards close relationships, and both subjective and objective effects of these relationships in the shape of relationship satisfaction and break up. Adults' attachment styles also have a great impact on how adults react to loss.

Research shows that different adult attachment styles are also related to different styles of coping with bereavement and continuing bonds and that those with insecure attachment styles have complications in their grief process (Bowlby, 1980; Field, 2006; Stroebe & Schut, 2005). Research indicates that individuals with an insecure attachment style report more adjustment problems when they go through a bereavement process (Field, 2006) and also tend to experience difficulties in finding support and to prolong their grieving (Schmidt,

Nachtigall, Wuethrich-Martone, & Strauss, 2002). There is empirical evidence to suggest that there are differences in patterns of emotional disclosure and support seeking according to attachment style (Mikulincer & Nachshon, 1991). According to Feeney (1999), to understand reactions to loss, it is very important to understand that attachment styles and different mental representations of self and other are related to the different types of emotional expressions in close relationships. Attachment theory is focussed on the relationships and bonds between people, particularly long-term relationships, including those between a parent and child and between romantic partners.

There is a limited amount of empirical research about the effects of adult attachment style on the grieving process after the loss of an attachment figure in adulthood despite the many theoretical models on bereavement experience in adults. Studies suggest that adults with an anxious-preoccupied adult attachment style experience more intense grief, stress, anxiety, and depression than adults who have a secure attachment style (Wayment & Vierthaler, 2002).

On the other hand, adults with an avoidant attachment style in their close relationships present less grief and distress as compared to other insecure attachment styles and they report rather inconsistently about their grief and related events. Research reports that adults with a dismissing avoidant attachment style show less anxiety and depression in reaction to the death of an attachment figure when compared to other insecure attachment styles but they report more somatic problems (Wayment & Wierthaler, 2002). Bereaved avoidant adults may suffer from somatisation as they pretend to appear careless and less affected by the bereavement experience while actually they experience it physiologically.

Adults with an avoidant attachment style seem more complicated in their

grieving process compared to adults with other attachment styles. According to Bartholomew (1990), avoidant individuals are divided into two groups: fearful avoidant and dismissing avoidant. Each type reports different experiences to loss and grief. In a study by Fraley and colleagues (Fraley & Bonanno, 2004), adults with secure and dismissingly avoidant attachment styles reported lower scores on depression, post-traumatic stress disorder, and maladaptive grieving than those with a fearful style.

Research indicates it is also important for the analysis of bereavement reactions to understand that attachment styles and their associated mental representations evolve as a result of different types of experiences related to the expression of emotions in relationships (Feeney, 1999; Kennedy-Moore & Watson, 1999). According to Feeney (1999), to understand reactions to loss it is important to understand how the different attachment styles and different mental representations of self and other are related to different types of emotional expression in close relationships.

A very significant relationship that is affected by unresolved loss in adults is the parent-child relationship. Attachment research suggests that parents who have experienced an unresolved loss tend to have disorganised infants (Main & Hesse, 1990). Due to unmanageable feelings of desperation, grief, and anger these parents cannot function as a source of security for their children. On the contrary, they often have outbursts of anger and exhibit other behaviours that the children find frightening. As the source of threat and the source of protection is the same, the parent, these children are unable to form an organized attachment strategy and develop disorganised attachment. Liotti (1992) suggests that frightening parental behaviour is the result of dissociative processes in parents who have themselves disorganised attachment – are classified as Unresolved in the AAI. However, Schuengel and colleagues (Schuengel,

Bakermans-Kranenburg, & van Ijzendoorn, 1999) found that unresolved loss in secure mothers did not predict infant disorganised attachment, while frightening behaviour in unresolved mothers did.

Numerous studies have shown that disorganised attachment in childhood is linked with a range of negative outcomes, including aggression and other externalizing behaviours, internalizing disorders, and peer problems (e.g. Fearon, Bakermans-Kranenburg, van Ijzendoorn, Lapsley, & Roisman, 2010; Groh, Roisman, van Ijzendoorn, Bakermans-Kranenburg, & Fearon, 2012). Moreover, Zajac and Kobak (2009) found that although parental experience of loss was not related to child behavioural problems, the experience of unresolved loss was. However, such unresolved loss was related to child problems only among insecurely attached mothers. Nonetheless, research suggests that parents classified as Unresolved in the AAI tend to have children with disorganised attachment (Verhage et al., 2016).

The role of parenting style

Baumrind (1971, 1989) and Maccoby and Martin (1983) reported that parenting styles work in two dimensions: Demandingness and Responsiveness. In demandingness parents are more controlled, demanding maturity and commanding while in responsiveness parents are responsive, supportive warm and involved. These dimensions are further divided into four parenting styles (Maccoby & Martin, 1983; Baumrind, 1991): Authoritative, Authoritarian, Permissive and Neglectful parenting styles.

Authoritative parenting style is a consistent and supportive parenting that improves child behaviour by setting appropriate limits and expectations (Baumrind, 1991). These parents have dual qualities: they exert control and provide support at the same time. However, in their control they are not very

strict and disciplinarian. This type of parenting style is child-centred and parents show interest in the child's activities. They participate in them and are involved (Grolnick & Ryan, 1989), openly chatting (Maccoby & Martin, 1983), maintaining their trust in their children (Pulkkinen, 1982), discussing openly child-related matters (Maccoby & Martin, 1983), encouraging their children to develop confidence and independence (Ginsburg & Bronstein, 1993). They are also highly alert to monitor the child's behaviour, their engagements, company, business, and keep an eye on them for their well-being (Steinberg et al., 1989; Barber, 1996). Baumrind (1991) reported that this parenting style depends on the parent's warmth and control.

The authoritarian style is one in which parents show less warmth and more rigidity and harshness; parents show more control but little support. Comparatively, they have low attachment and association with their children. They normally do not trust their children and are less connected with them. They shatter their children's confidence level and discourage them in communication; they are very strict. This type of parenting style is adult-centred (Maccoby & Martin, 1983) and often results in problems in the parent–child relationship as children think that their parents devalue, condemn, and overcontrol them (Baumrind, 1971; Barber, 1996).

The permissive parenting style fails to set limits and ignore improvement in children according to expectations (Baumrind, 1991). These parents are very supportive and more responsive while less controlling. This is the most accepting parenting style and parents allow warmly whatever their children demand. This type of parenting style is based on a child-centred relationship (Maccoby & Martin, 1983; Baumrind, 1989). Comparatively, permissive parenting style is less demanding and has no disciplinary control on children and parents want their children to behave normally, freely, and independently (Baumrind, 1991). The

neglectful parenting style is low in both control and support. Parents do not use warm words that encourage and improve the progress of their children. Neglectful parents show negative supervision that increase child behaviour problems (Maccoby & Martin, 1983). Contrary to other parenting styles, these parents have no involvement but also no control (Maccoby & Martin, 1983; Baumrind, 1991).

Baumrind (1991) reported an association between parenting styles and behaviour problems in young people. Both authoritarian and permissive parenting styles have been linked with the development of negative behaviour problems in children, such as drug addiction, negative behaviour in school, and delinquency (Baumrind, 1991; Slicker, 1998). On the contrary, authoritative parenting style is associated with positive behaviour in children as such children are at low risk of developing behavioural problems (Bronte-Tinkew et al., 2006; Slicker, 1998).

Parenting styles differently influence children in their behaviour and overall competence and performance in life. Children whose parents have authoritative parenting style show high adaptability to new schools and more achievements (Dornbusch et al., 1987) and think positively about school (Maccoby & Martin, 1983) as their parents critically support them in solving their problems on their own (Hess and McDevitt, 1984). Children whose parents show an authoritarian parenting style are more dependent and always feel under parent control. They are continuously discouraged by parents to solve their problems and therefore develop low confidence in exploring the world around them (Hess & McDevitt, 1984). These children are more passive as their authoritarian parents use excessively administrative behaviour (Steinberg et al., 1994). They also have low school performance and make less progress (Pulkkinen, 1982).

Children whose parents are permissive or neglectful develop irresponsible, uncontrollable, and negligent behaviour as they are taught no proper rules and boundaries from their parents (Barber, 1996). In addition, they cannot focus on their studies and show less achievement in school (Maccoby & Martin, 1983; Baumrind, 1991). In conclusion, neglectful and permissive parenting styles are linked to children's lack of competence and little progress in life (Onatsu-Arvilommi & Nurmi, 1997).

A small number of research studies has associated parenting style to the achievement of children (Nolen-Hoeksema et al., 1995). Most of these studies have focussed on primary school children and show that parenting qualities relate with how children will progress in school (Baumrind, 1991). The conduct problems children and adolescents develop mostly depend on parenting style and how parents perceive their child's behaviour (Bugental & Happaney, 2002).

Sometimes parents decrease their tolerant behaviour towards their children as children grow up, increasing in a harsher and more domineering parenting style (Loeber et al., 2000; Straus & Stewart, 1999). As children grow older, parenting laxness and a permissive style in which parents cannot enforce rules decreases (Loeber et al., 2000). This may be due to the maturation of children's cognitive abilities that brings age-related changes to the parents' views about their children (Collins, Madsen, & Susman-Stillman, 2002). On the other hand, parenting styles affect child conduct by applying stricter rules and more controlling strategies.

Parenting style high in laxness has limitations with respect to proper communication with children; parents have less control in setting rules to facilitate positive behaviour in children and take fewer chances to groom their children as compared to parents with other styles (Darling & Steinberg, 1993).

Similarly, parenting overreactivity has a great impact on child conduct problems in many ways as described in various theories, such as, for example, the theories of social control, social information processing, biological theories, and theories of moral internalization (Bugental & Grusec, 2006). According to behavioural theory, parental laxness and overreactivity are forcing and bullying parenting styles, promoting hostility rather than prosocial behaviour and ending up in conflicts (Reid, Patterson, & Snyder, 2002). They are regarded as a type of coercion that increases child behaviour problems and research shows that child conduct problems change when there is a change in parental laxness and overreactivity (Patterson, DeGarmo, & Knutson, 2000).

Research has reported a close association between a negative parenting style and child problems, but parenting style can be improved by skill training programmes that also improve thyoung people's behaviour and decrease their behavioural problems (Taylor & Biglan, 1998).

Complicated or unresolved grief

Research is still in progress investigating factors involved in family grief, which remain unresolved. Studies have identified a number of factors associated with social and psychological problems that relate to the reaction and determination of the bereaved. They include, for example, the cause of the death (Zisook, Schucter, & Lyons, 1987), the bereavement history of the bereaved (Zisook, Schucter, & Schuckit, 1985), the level of support from the family, friends, and society (Maddison & Walker, 1967), and demographic background such as age, gender, social status, and economic status (Zisook et al., 1987).

Stroebe and Stroebe (1987) report that bereavement experience may affect the bereaved mentally and physically, long-term and sometimes even cause the death of the bereaved. Bereaved parents due to the child's death are especially

vulnerable (Nolen-Hoeksema & Larson, 1999). Moreover, coping with a bereavement experience in adulthood is difficult for individuals who experienced loss or separation from parents in their childhood (Bowlby, 1980).

There is a correlation reported between behaviour problems in bereaved children and the parents' communication about death as well as the support provided to the latter for their own distress (Martinson & Campos, 1991). Research reports that the parent's role in the home is like that of a therapist as they try to improve the bereaved child's behavioural problems (Hawkins, Peterson, Schweid, & Bijou, 1966).

Attachment theory claims that revising the attachment bond to the deceased is a kind of adaptation to the loss (Bowlby, 1980). It may be possible that bereaved children continue their bond with the deceased (Horsley & Patterson, 2006). Securely attached children can tolerate the separation without great depression and more easily overcome bereavement while insecurely attached children show a variety of negative emotional reactions to the death experience. Nonetheless, research shows that most bereaved children move on in their life and deal with their distress without professional support (Currier, Holland, & Neimeyer, 2007).

A number of studies provide evidence that as the adult child–parent relationship continues to be emotionally very important (Scharlach, 1987); the death of a parent has a great psychological and mental health impact on an adult offspring's mind (Bowlby, 1980). When a parent dies, the surviving adult child may develop serious distress symptoms and intense feelings of loss (Horowitz et al., 1981). The reaction to such bereavement may lead to negative thinking, for example, "everything is mortal and therefore meaningless", and the life of the bereaved may change, including the family members' roles and relationships (Angel, 1987).

Along with other family deaths, the death of a spouse also has a great impact on

an individual's socio-psychological life (Parkes & Weiss, 1983). Attachment theory suggests that individuals and relationships guided by an anxious attachment style and involve dependency, ambivalence, and overall anxiety find it really hard to go through the bereavement process (Bowlby, 1979). Sometimes children take parenting roles and the parent becomes the child (Detmer & Lamberti, 1991) as the surviving family tries to cope with the bereavement of an adult.

However, among all types of bereavement experience the most severe is the death of a child, as it may cause traumatic complications in the grieving process and trigger an unresolved grief reaction (Prigerson et al., 1999). It is really hard for a parent to experience such a loss and see the attachment relationship with their child terminated and the experience may bring severe depression and anxiety as well as other negative emotions (Bowlby, 1980). For example, a parent may feel guilty of being responsible for the child's death and their inability to save it (Gilbert, 1997). The unexpected death of a child disturbs life events that had been planned and presents a huge challenge (Wheeler, 2001).

Stroebe, Stroebe, and Abakoumkin (2005) reported that individuals with intense bereavement experience that causes isolation and anxiety are at risk of very negative outcomes such as suicide. Parents, especially mothers, grieving for a child are at high risk of psychological disorder and hospitalization compared to parents having no such experience (Li, Laursen, Precht, Olsen, & Mortensen, 2005). Further, the mortality ratios in bereaved parents within the first three years after the death of their child is very high as compared to the non-bereaved, according to the Danish national registries, especially when the child died unexpectedly and unnaturally in an accident or by suicide (Li, Precht, Mortensen, & Olson, 2003).

Social and family relationships, particularly the relationship between the parents, may be seriously affected by the experience of bereavement (Najman et al., 1993). Research shows that divorce ratios are about eight times higher in bereaved parents when compared to the non-bereaved (Lehman, Wortman, & Williams, 1987). Although the grieving time is different for different parents, the majority grieve indefinitely (Klass, 1999). Bereaved parents may try to get involved in various activities, such as trying to find more work and get busy in social activities and being involved with religious ceremonies (Sherkat & Reed, 1992). Some may have another child or devote and focus more on the surviving children (Najman et al., 1993).

Family relationships and support can help coping with stressful events including bereavement (Kobak & Sceery, 1988; Mikulincer & Florian, 1998). If family bonds are based on secure attachments, it becomes easier to tackle emotional grief (Mikulincer et al., 1998). On the other hand, insecure attachment brings risks following bereavement (Bartholomew & Shaver, 1998).

Finally, we need to distinguish between unresolved grief and adaptive continued bonds with the deceased. Studies suggest that continuing bonds to the deceased can be a source of healing. The bereaved often continue their bonds by different activities suchas talking to deceased, keeping some of their belongings,writing poetry or even the biography of the deceased (Field, 2006; Talbot, 2002). If the bereaved keeps a sense of reality and their everyday functioning is not impaired, continued bonds could be adaptive, challenging some ideas in the stage models of grief.

In this chapter relevant previous studies on bereavement and attachment were discussed. First, more general studies on bereavement and then, an introduction to attachment research were presented, covering important studies on

attachment in childhood and adulthood. Finally, important studies approaching bereavement from an attachment perpective were discussed and research on parenting styles was presented.

CHAPTER TWO
AIMS AND RATIONALE OF THE THESIS

The aims and objectives of the current investigation are to explore how attachment theory can be utilised in understanding the experience of bereavement in children. This was attempted by conducting three empirical studies – one qualitative and two quantitative. The aim of Study 1 was to relate the experience of bereavement in childhood to current attachment style in adulthood and to explore how university students with different attachment styles produce different narratives about their childhood bereavement. The aim of Study 2 was to clarify how parental care in childhood was linked with unresolved grief in adulthood among individuals who lost a caregiver as children, while the aim of Study 3 was to explore the moderating role of parental unresolved grief, adult attachment, and parenting style on the impact of bereavement on child behavioural problems.

Four samples were studied to address the objectives: two samples of adults who experience bereavement in childhood, a sample of mothers with children who had experienced some significant bereavement, and a sample of parents whose children had not experienced bereavement. Previous research on retrospective accounts on bereavement and attachment is limited and so is the research linking parental attachment and unresolved grief and child problems in bereavement.

General Methodology

Both qualitative and quantitative approaches were used in this work. The qualitative study was employed in order to obtain richer data in depth while the quantitative study aimed to identify causal relationships between variables. The use of both types of method allowed methodological triangulation. Webb et al.

(1966) proposed that when two or more methods are used to address a research question, the results become more credible and uncertainty is reduced. Previous studies show that researchers such as Kimchi et al. (1991) and Cobb, (2000) have used two data collections from the same research design.

A number of researchers have used both quantitative and qualitative methods in their between and across method triangulation (Lincoln & Guba, 2000; Denzin, 1970), combining different methods across and within studies. According to Thurmond (2001), research is enhanced when both qualitative and quantitative research methods are combined in the same study and Denzin (1978) suggests that using triangulation and combining two methods overcome the flaws of each individual study and gives the best overall effect to the observer. Triangulation may also have disadvantages as it needs an extended period of time to complete as compared to a single method (Thurmond, 2001) and may be difficult to use with large amounts data.

Study 1 addressed two research questions:

1. Do adults with different attachment styles generate different types of narratives about their childhood bereavement experience?
2. What would those differences be?

Study 2 explored one research question (what are the best predictors of adult complicated grief among indices of parental care) and tested eight research hypotheses:

1. Complicated grief would be positively related to parental protection, separation anxiety, adult attachment avoidance, and adult attachment anxiety.
2. Complicated grief would be negatively related to parent care.
3. Adult attachment style (both anxiety and avoidance) would mediate the link between paternal care (maternal and paternal) received in childhood and complicated grief in adulthood.
4. Adult attachment style (both anxiety and avoidance) would mediate the link between parental overprotection (both maternal and paternal) received in childhood and complicated grief in adulthood.
5. Adult attachment style (both anxiety and avoidance) would mediate the link between separation anxiety experienced in childhood and complicated grief in adulthood.
6. Adult attachment style (both anxiety and avoidance) would mediate the link between parental care received in childhood and complicated grief in adulthood.
7. Adult attachment style (both anxiety and avoidance) would mediate the link between parental overprotection received in childhood and complicated grief in adulthood.
8. Separation anxiety in childhood would mediate the link between quality of parental bonding in childhood (both care and overprotection) and complicated grief in adulthood.

Finally, Study 3 tested ten research hypotheses.

1. The bereaved children were expected to report more behavioural problems than non-bereaved children.

2. Among the bereaved children, child behavioural problems were expected to have significant positive correlation with both parent attachment dimensions, parent-complicated-grief, parenting style, duration of bereavement, and closeness with the deceased.

3. Among the bereaved group, children's reaction to bereavement was expected to have significant positive correlation with both parent attachment dimensions, parent-complicated-grief, parenting style, duration of bereavement, and closeness with the deceased.

4. Both parent attachment dimensions (anxiety, avoidance) would moderate the link between bereavement status (bereaved, non-bereaved) and child problems (SDQ). It was expected that bereaved children whose parents had relatively high attachment anxiety/avoidance would have more behaviour problems compared to those whose parents have low attachment anxiety/avoidance while the level of the behaviour problems among non-bereaved children would not be affected by the attachment anxiety/avoidance of their parents.

5. Parent-complicated-grief would moderate the link between bereavement-status and child-problems (SDQ). It was expected that bereaved children whose parents had relatively high unresolved complicated grief would have more behaviour problems compared to those whose parents have low unresolved complicated grief while the level of the behaviour problems among non-bereaved children would not be affected by unresolved complicated grief by their parents.

6. Parentingstyles (PS-Laxness, PS-Verbosity and PS-Overreactivity) would moderate the link between bereavement status and child problems (SDQ). It was expected that bereaved children whose parents had

relatively high laxness/overreactivity/verbosity would have more behaviour problems compared to those whose parents have low laxness/overreactivity/verbosity, while the level of the behaviour problems among non-bereaved children would not be affected by attachment laxness/overreactivity/verbosity by their parents.

7. Parental attachment avoidance and attachment anxiety would be the strongest predictors of child behavioural problems measured by the SDQ and the CSQ.

8. Both parent attachment dimensions would moderate the link between parent-complicated-grief and child problems (SDQ and CSQ). It was expected that children, of the parents having unresolved complicated grief had relatively high attachment anxiety/avoidance, would have more behaviour problems compared to those whose parents have low attachment anxiety/avoidance while the level of the child behaviour problems of the parents having unresolved complicated grief would not be affected by attachment anxiety/avoidance by their parents.

9. Both parent attachment dimensions would moderate the link between parenting styles and child problems. It was expected that children, of the parents having laxness/overreactivity/verbosity and had relatively high attachment anxiety/avoidance, would have more behaviour problems compared to those whose parents having low attachment anxiety/avoidance, while the level of the child behaviour problems of the parents having laxness/overreactivity/verbosity would not be affected by attachment anxiety/avoidance by their parents.

10. Parent-complicated-grief would moderate the link between parenting styles and child problems. It was expected that children of parents having laxness/overreactivity/verbosity who had relatively high

unresolved complicated grief, would have more behaviour problems compared to those whose parents having low unresolved complicated grief while the level of the child behaviour problems of the parents having laxness/overreactivity/verbosity would not be affected by unresolved complicated grief by their parents.

In this chapter, the rationale and aim of the whole thesis were presented, along with the aims and research questions and hypotheses of each specific study.

CHAPTER THREE
STUDY ONE

Aim and Research Question

The purpose of this study was to utilise attachment theory in understanding the experience of bereavement in childhood. The aim of Study 1 was to explore how experience of bereavement in childhood is remembered in adulthood and more particularly, how current adult attachment style informs that memory. Studies have shown that insecure attachment is related to problems in bereavement (Field, 2006). However, relevant research has focussed mostly on adults. This qualitative interview-based study utilised thematic analysis and aimed to advance our knowledge in the field of child bereavement.

Research Questions and Objectives

Study 1 was a qualitative interview-based study utilising thematic analysis to address two interrelated research questions: Do students with different attachment styles generate different types of narratives about their childhood bereavement experience? What would these differences be? To collect and study retrospective accounts of bereavement experience a qualitative methodology was appropriate as it would generate rich data. The aim of the study was to capture the personal experience of university students about their childhood bereavement based on their memory of events and feelings, not necessarily to obtain an exact account of events. The main concern of this study was not what "actually" happened but how participants remember and describe whatever happened – their subjective experience.

Methodology

Research Design

University students were recruited for a semi-structured interview after being classified into one of four attachment styles. Classifications were based on their completion of the Experiences in Close Relationships Questionnaire (Fraley, Waller, & Brennan, 2000) and those attachment styles were: secure, preoccupied, dismissing, and fearful. Data were analysed using thematic analysis.

Participants

Twenty-four participants were selected for this study. The study was limited to university students over the age of 19 and had experienced the death of a parent, grandparent, sibling, friend, or any other close prson during childhood. All participants in this study had lost a close family member or a friend to death during childhood. At the time of death, participants were 7–16 years old and now they were 21–43 years old. Mean time from death was 18.4 years. Eleven participants were undergraduate students and 13 were post-graduate. Nine were British and 15 were non-British students. Currently, they were studying psychology, social work, business, biomedical science, information systems, international human resources management, computer networking, sports therapy, criminology, and midwifery. They belonged to different ethnic groups, including Black African, White, Pakistani, Indian, and other Asian. Thirteen were married and 11 were in long-term relationships. Out of the total of 24 participants, 6 came under each attachment style, according to ECR scores.

Research Instruments of Data Collection

The following questionnaires were used for data collection:

a. *Experience in Close Relationships Questionnaire* (ECR; Fraley, Waller, &

Brennan,2000).

This is a 36-item questionnaire to measure attachment-related avoidance and attachment-related anxiety in adults. Eighteen odd items measure ECR-Avoidance, with nine reversed key items, while 18 even items measure ECR-Anxiety, with one reversed key item. These two attachment dimensions were used to assess four attachment styles. Scores are from 18 to 126, and the midpoint is 72. Low scores (below 72) in both avoidance and anxiety indicate a Secure attachment style. Low scores in avoidance but high scores (above 72) in anxiety indicate a Preoccupied attachment style. Low scores in anxiety and high scores in avoidance indicate a Dismissing attachment style, while high scores in both anxiety and avoidance indicate a Fearful attachment style.

In a study by Hazan and Shaver (1987), the researchers asked participants to complete the questionnaire about the most recent partner if they did not have a partner currently. They were asked to rate their intimate relationships on 7-point Likert scale where 1 is strongly disagree and 7 is strongly agree. Their scores range from 18 to 126, where 72 is borderline that indicates the person is low or high in avoidance or anxiety. According to Brennan and Shaver (1998), higher attachment Avoidance and Anxiety is indicated by high scores in avoidance and anxiety subscales.

A dimensional approach to adult attachment has been recently advanced by adult attachment researchers (Brennan, Clark, & Shaver, 1998; Fraley, Waller, & Brennan, 2000). Early research used to measure three dimensional adult attachment styles (Simpson, 1990; Collins & Read, 1990). Brennan et al. (1998) promoted a new measure including all previous attachment measures and termed the factors as *anxiety* and *avoidance.* The ECR questionnaire was also based on Bartholomew's model of self and other (Brennan et al., 1998). Fraley et

al. (2000) improved the ECR and now it is the most valid measure to assess attachment anxiety and attachment avoidance in adults. ECR-R exhibits internal and test–retest reliability in both its dimensions (Fraley et al., 2000). Participants who completed the questionnaire were classified into one of the four attachment styles (secure, preoccupied, dismissing, and fearful), based on their questionnaire scores.

b. Semi-Structured Interview on Childhood Bereavement

This is a semi-structured interview asking participants to describe their childhood experience of the loss including their feelings, thoughts, and behaviour at the time, family and friends' support and any change in their feelings over time. I arrived at the interview questions after reading the relevant literature on bereavement and attachment. A retrospective interview may not present an exact account of events. However, my main concern was to capture not what actually happened but how an individual remembered the childhood events relating to the loss. Twenty-five open-ended questions were asked to get the main essence of participants' bereavement experience, their feelings, and reactions to the bereavement. (See Appendix I for the detailed interview schedule). Those included, for example, 'What could you tell me about the person you lost in your childhood?', 'What was his/her relation to you?', 'Could you talk to me a bit about your life at that time?', 'Was that person important to you in any way – why?', 'Could you talk to me about how you felt when you heard about the loss?', 'How did you react?', 'How do you think people around you felt/reacted?'

A qualitative semi-structured interview was an appropriate method for data collection in the study of childhood bereavement experience as it allows interviewees to be open and helps them to explore different themes. It is flexible

to new ideas that may emerge during the interviewing process. The researcher makes a list of a number of questions in advance to be asked as appropriate. However, the interviewer is free to follow up these questions adapting to the participant's particular situation. According to Fylan (2005), semi-structured interviews are the most diverse, flexible, and effective ways to obtain credible accounts of participants' thoughts, feelings, and experiences, and participants present more valid responses during an interview than in a questionnaire (Gordon, 1975). Moreover, a semi-structured interview allows researchers to develop rich methods of data analysis, for example, to generate different codes and themes from the participants' life experience (Kvale, 1996).

Procedure

All participants had some experience of bereavement in childhood. I announced the study to fellow students I already knew and personally approached the other participants in the university campus with discretion and gave them verbal information on the nature of my study. When they initially agreed to take part in the study, before the interview began, I asked two questions to identify potential vulnerability. I asked 'Could you say that the loss you wanted to talk about upsets you a lot still at the present time?' and 'Are you currently suffering, or have recently suffered, from intense psychological stress or a mental health problem?' If participants answered positively to either of those questions I politely explained to them that perhaps it would not be a good idea to take part as the interview might be too upsetting for them. When they could and agreed to participate, I gave them an informed consent form and a debrief form. Then participants completed the ECR and then took part in the interview. Interviews lasted for about thirty minutes and took place in pre-booked university rooms that were suitable and comfortable for the participants. No one could disturb us during the interview and all interviews were audio-taped with the permission of

the participant and then transcribed.

Ethical Issues in the Study

It is the utmost duty of a researcher to promote the respect and autonomy of participants. I was fully aware that my research involved a very sensitive topic and therefore I approached the whole research process, particularly data collection, with extreme caution. I applied the BPS ethics code throughout and I attended meetings with my supervisors so that I received the appropriate training and would administer data collection properly. As in most cases the deceased would be expected to still be close to the participant and therefore the participant would be in a potentially vulnerable position. To minimize potential distress in the participant I took the following additional measures:

a. I allowed enough time for participants to think carefully whether they were certain they wished to participate in the study – I allowed three days between first participant contact and interview administration.
b. Prior to the study commencing, I asked if they suffered from any serious stress including an important recent bereavement or psychiatric illness. If they did, they were excluded from the study.
c. I was vigilant throughout the study for any signs of participant distress or hesitation. If I observed such signs or was asked directly by the participant I interrupted the interview, postponed it, or cancelled it.
d. I provided information about the study in writing and verbally and took a written consent from participants.
e. Participants were reassured that information would be anonymous and strictly confidential and all data would be kept safe. The data collected for this study were kept carefully in my personal locked

cupboard to maintain confidentiality, and participants were fully aware that their name and identity would remain confidential and would only be used for academic purposes. I assigned a code number to every participant and that was used in the process of transcription and analysis. Real names and signed consent forms were kept locked up.

f. Although I was expecting participants not to be under serious distress, mild distress was possible, even later after interview completion. To address that I provided participants with the contact details of local bereavement/counselling organizations including the university counselling services. Also, they were given my contact details and those of my supervisor for any questions or comments they might have.

In designing and conducting my research I had reflected on the methodological and ethical issues in bereavement research discussed in the relevant literature, for example, by Stroebe, Stroebe, and Schut (2003): issues such as the benefits and limitations of using quantitative and qualitative methods in researching with those that have been bereaved. Also, I recognized that those who have been bereaved may not admit to themselves or the interviewer feelings of psychological distress as this goes against social norms of grieving (Stroebe et al., 2003). Although it was challenging for me to enquire about sensitive details from individuals of very different cultural and ethnic backgrounds, I found that all data collection was conducted very successfully and participants responded very positively.

Data Analysis

A thematic analysis, a method used to analyse qualitative data, was used to

identify main themes in participants, as described by Boyatzis (1998). Braun and Clarke (2006) proposed thematic analysis as a useful and flexible method for qualitative research in and beyond psychology. While Barun and Clarke (2006) have provided ways to approach thematic analysis, Boyatzis (1998) has proposed how to validate codes and themes by a variety of methods. Therefore Boyatzis' work was used as a guide in current analysis.

Boyatzis proposed three phases in thematic analysis. In the first phase sampling and research design are finalized, in the second phase themes and codes are evolved and in the final phase codes are validated and analysed. The basic approach to qualitative study is the thematic analysis that has variety and complexity (Holloway & Todres, 2003). According to Boyatzis (1998), thematic analysis is a pathway to get access to other methods rather than simply one more method. Ryan and Bernard (2000) described thematic analysis as an analytic process within a process. One advantage of thematic analysis is that it could be applied in data-driven and as well as theory-driven research testing hypotheses (Holloway & Todres, 2003). On the other hand, authors argue that thematic analysis is not an orderly arranged process, rather a slow and steady process of moving backward and forward to develop themes and codes (Ely et al., 1997).

In this study, thematic analysis was completed in two steps.

Step One: Preparation of the data

Riessman (1993) reported that to recognize the best themes, the recorded interviews should be converted into transcripts, which is a long and tedious process, perhaps more so than main phase of the analysis itself (Bird, 2005). As discussed already, that data was collected using a semi-structured interview, which was recorded and then transcribed. As English was not my first language,

the transcribing process was done in two steps: first by me to the best of my knowledge and than by professional transcribers to capture particular accents. Professional transcripts were again matched and checked against the recording. As language barriers were always there, it was important to recruit professional help to avoid misunderstandings and eventually, incorrect coding. Data was kept confidential by removing the original personal details and giving pseudonyms. Interviews were transcribed and analysed without knowing the participant's attachment style in order to avoid bias in the analysis.

Step Two: Coding the interviews

The participants narrated their experiences of family, friends, and school situations at the time of death of their close ones, their reactions and feelings at death news, their family's reaction, support from family and friends, description of deceased, and change in their feelings with the time. Participants had death of a close one during childhood or early teenage but reported different circumstances.

An inductive approach is used to thematic analysis to derive different codes and themes from transcripts, explicitly. Every sentence of the narrative was examined by repeated reading sessions many times, to identify different codes related to bereavement experience, then the general themes evolved from those codes. Thematic analysis is not just transfer of the spoken words to a written document, rather a creative process to identify different meanings of those words (Lapadat & Lindsay, 1999). This process was completed in two phases.

Phase 1

Tables 1–3 present the findings of the first phase of analysis. In the first phase I identified very detailed "codes" that describe the Self and the important Other

that was lost in relation to important attachment issues, emotional needs, support provision, loss. According to attachment research, representations of self and other are the building blocks of attachment representations. For example, Bartholomew and Horowitz (1991) examined a model of individual differences in adult attachment style based on individuals' internal model of the self and that of other (positive or negative). In the current study descriptions came either directly from the participant's talk about self and other or indirectly, out of the narration of an event in which the self appears to be sad. During analysis in Phase 1, I made notes of all such descriptions at the margins of the each interview transcript.

I identified 34 codes corresponding to different descriptions of the Self at the time of the loss (Table 3.1).

Table 3. 1

Codes describing the Self around the time of bereavement, according to attachment style

DESCRIPTIONS OF THE SELF	**FREQUENCY OF OCCURANCE**			
	Secure	**Preoccupied**	**Dismissing**	**Fearful**
Sad	6	6	6	6
Shocked	3	5	3	3
Lonely	4	2	5	3
Fearful	2	1	1	1
Guilty	1	-	1	-
Angry	3	-	-	1
Suppressing grief	2	2	3	1
Tearful	2	2	5	4
Declining in school performance	1	3	1	2
Seeking	2	1	-	2
Dreaming	-	1	-	1
Having psychological problems	1	1	1	1
Insecure	-	-	1	-

Having little understanding of death	1	1	-	-
Having a sense of disappearance	-	1	-	-
Having late realization of loss	1	2	-	1
Getting ill	-	-	1	-
Disappointing	1	1	-	-
Avoiding to talk	1	-	2	3
Regularly visiting grave	-	-	1	-
Stopped eating	-	-	1	1
Getting mature	-	-	2	-
Turning to deceased in bad times	-	2	-	-
Couldn't cry	-	1	1	-
Pitiful	-	1	-	1
Empty/vague	-	2	-	-
Disbelieving	-	1	-	3
Feeling bad	-	1	-	-
Feeling headache	-	1	-	-
Smoking	-	1	-	-
Blessing in church	-	1	-	-
Turning within self	-	1	-	1
Self is separating from deceased	-	-	-	1
Hurting	-	2	-	1
Confusing	-	1	-	-

Below, descriptions and quotes are presented to illustrate some codes for the Self.

Tearful

This code refers to instances in which participants were in tears when they heard or thought about the loss.

"I can't remember anything else apart from that I was crying so much that

> I hadn't noticed that everybody else had left the lecture theatre…some children would kind of climb over me to leave the theatre. The next thing I remember was a member of staff was coming up to me because I was sitting and crying and, then, I realized that I was the only child left."(Participant 1, p.2)

Suppressing grief

This code evolved from accounts of participants reporting how they had to hide feelings of grief.

> "In those days I think we were not expressive in our feelings you know – I don't remember real grief. We were kind of being a tearful and a bit quiet. We were waiting to go to our home. We were protecting ourselves from others because our auntie said we should be strong enough for our mum. I remember her to say come on, be strong for your mum. When she come home the key thing is that we repress our feelings". (Participant 12, p.2)

Disbelieving

This code describes participant's childhood feelings of disbelief regarding the loss.

> "When I was told it was like my heart stopped, it was, I couldn't believe it. I just could not believe it because he wasn't ill. He was a sort of mid-seventies so wasn't that old and he was a fit man. You know he used to go for walks. He used to go for fishing; he used to go for all sorts... He did skiing, you know in Norway, a very healthy life style. He always worked with his hands you know, he had been a baker, and he loved his

gardening. He was a fit happy person. He wasn't overweight, nothing." (Participant 14, p.2)

Couldn't cry

This code evolved from participant's accounts in which feelings were so strong that participants could not cry.

"It's interesting because for one week I was so disappointed so I can't cry and your tears are not enough to express." (Participant 3, p.2)

Little understanding of death

This code refers to participant's difficulty to understand what happened, to realize the loss.

"Oh I gave my dad a hug and went outside to play. Really, it wasn't like, I said I really didn't understand the meaning, I didn't understand I wasn't going to see him anymore." (Participant 9, p.2)

Lonely

This code was derived from accounts of loneliness relating to the death of the loved one.

"I can't explain too much, I was sad, very sad. I liked to stay alone. I wanted to be alone but you know people used to come to support me". (Participant, 13, p.3)

In addition, feelings the participant holds about the deceased today were identified and classified in 35 codes as contracts between the Self then and the Self now were often made in the transcripts (Table 3.2).

Table 3.2

Codes describing the current Self according to attachment style

Themes	**FREQUENCY OF OCCURANCE**			
	Secure	**Preoccupied**	**Dismissing**	**Fearful**
Missing	6	6	6	6
Remembering	6	6	6	6
Feeling happy with memory	6	3	4	3
Having change in sadness	4	3	4	1
Same feelings	2	2	2	4
Still talking about	2	3	5	3
Having patience	1	1	-	-
Dreaming	1	4	-	-
Fear of getting close to others	-	1	1	2
Wishing the deceased to be alive	-	2	1	2
Still crying	1	-	2	-
Feeling sorry	1	-	1	1
Keeping things as memorial	1	1	1	-
Controlled	1	1	1	-
Strong	3	2	1	-
Visiting grave	1	-	-	-
Having a need in bad times	-	1	1	
Lonely	1	-	-	-
Avoiding to visit deceased's house	-	1	-	1
Relaxing in temple	2	1	-	-
Cannot dragging out	-	1	-	-
Wishing if happened later	-	-	2	-
Giving same name to daughter	-	-	1	-
Memories are in head	1	1	-	1
Thinking about good times together	-	1	2	1
Cannot forget	-	2	1	-
Getting depressed whenever think	-	1	-	1
Idealizing the deceased	-	2	1	-
Valuing things more	-	-	-	2

Praying	-	1	-	1
Wishing deceased visited in dreams	-	1	-	-
Superstitious	-	1	-	-
Close than when alive	-	1	-	-
Stress and headache	-	1	-	-

These are examples of some codes describing the current feelings of participants towards the deceased and their past experience of bereavement.

Having changed in sadness

This code describes accounts suggesting that feelings change may over time – the deceased may still be missed but perspective may be different.

> "What is happening in your life at that time and should grow up. So maybe you don't have the same intensity of feelings now when you do think about it. You feel sadness but you don't feel like "I am sad". You feel that this was a sad thing that happened but you don't… and you know that there is a feeling of sadness but you don't experience it at that same level when you are older looking back now." (Participant 1, p.4)

Fear of getting close to others

This code evolved from accounts of participant suggesting fearful and insecure feelings about making close relationships, as a result of the loss.

> "Sometimes I get scared being close to people like what if I lose them, what if they go away. What I am going to do then? But then I get these feelings you know that he passed away, I go on with life. I met other people. Life doesn't stop so… sometimes I get scared getting close to people, just because I don't want to lose them." (Participant 16, p.4)

Feeling happy

This code was evolved from accounts of positive feeling in memories of the deceased.

> "When I look back I can picture her, I can picture her house. It is fine and it doesn't hurt me anymore. I can do that and feel glad." (Participant 12, p.4)

Wishing the deceased to be alive

This code was evolved from narratives of continuing longing for the deceased.

> "Today if I remember I always just think that she would have been here how happy she would have been to see how I am on this position and I am studying for a PhD and I am here independent with all my own struggle in London completed my masters, independent as she wanted the girls to be." (Participant 6, p.4)

Wishing deceased visit in dreams

This code was developed from account of turning to spirituality and wishing the deceased visiting in dreams and continues the bond.

> "Ok, I am very spiritual myself, my sister isn't, she is really opposite. Sometimes I talk about the dead come and visit in your dreams, I am very spiritual like that and my sister doesn't believe in that." (Participant 23, p.5)

Having Patience

This code was developed to describe accounts of participants 'feelings of

patience in facing the loss of loved one, hoping that eventually the permanence of the loss will be accepted'.

> **"**And after that, what I got from this experience is that I have to be patient, especially when you love someone and you lost him, it's so difficult. That's why we had to be patient about that. I had to understand everything logically, we all going to die, you know. But sometimes it's difficult to live without someone you love". (Participant 8, p.5)

In addition to the codes describing the Self, 49 codes describing the Other (the deceased) were identified (Table 3.3).

Table 3.3

Codes describing the Other (deceased) according to attachment styles

DESCRIPTIONS OF THE DECEASED	**FREQUENCY OF OCCURANCE**			
	Secure	**Preoccupied**	**Dismissing**	**Fearful**
Supportive	3	5	3	4
Caretaker	2	3	3	3
Loving	1	3	4	4
Nice	3	3	4	1
Friendly	4	1	3	3
Fatherly figure	1	4	4	2
Had a good sense of humour	-	2	-	3
Helpful	1	1	-	2
Sudden illness	1	1	-	4
Long illness	-	1	4	1
Close	2	1	1	2
Guide	1	3	2	1
Inspiration	1	1	-	-
Good behaviour	-	1	-	1
Honest	-	1	-	1
Had patience	-	1	-	-
Taking us out	-	-	2	1
Lived abroad	-	-	1	-

Indirect impact	-	-	1	-
Adored by mum	-	-	1	-
Serious	-	-	1	-
Disciplined	-	1	1	-
Best person	-	1	1	-
Only grandparent	-	-	1	-
Only male in family	-	1	-	-
Wonderful person	-	1	1	-
Taught violin	-	-	1	-
Taught drawing	-	1	-	-
Taught religion	-	1	-	-
Present in all events	-	2	-	-
Suicide	1	1	-	-
Important for mum	-	1	-	-
Important for dad	-	1	-	-
Smiling face	1	-	-	1
Same roots	1	-	-	-
Aback child	1	-	-	-
Sweet boy	2	-	-	-
Drug addicted	1	-	-	-
Bad character	1	-	-	-
Critical	1	1	-	-
Disappointed	1	-	-	-
Guilty	1	-	-	-
Religious	-	1	-	-
Educated	-	1	-	-
A family woman	-	1	-	-
Good hearted	-	1	-	-
Playful	1	-	-	-
Golden haired	-	-	-	1
Business minded	-	1	-	-

Caretaker

This code was developed from narratives presenting the deceased as a primary caretaker and supporter.

"I think my mum was a single mum; she wasn't very good at being a single

parent at all. If there hadn't been my granddad, I don't think me and my brother would have actually stayed with my mum. We could have been taken away from her. It was my grand dad, he really looked after us, made sure that, you feed and cloths and everything like that". (Participant 14, p.2)

Taking us out

This code was derived from accounts of the deceased as a source of joy and fun.

"He was my uncle. I was very close to him; the whole family was very close to him especially us kids. He used to come after school like for lunch than take us out on the weekends, bring us stuff to eat like you know, he used to work on a store somewhere and he used to buy stuff and everything, he was the only person we used to go out with on weekends, so quiet close to him." (Participant 16, p.1)

Best person

This code was developed based on accounts of the deceased as excelling in every role of life.

"Best granddad, best husband to my grandmother, best father to my dad and best grandfather to me." (Participant 9, p.3)

Present in all events

This code was developed from accounts indicating that the deceased was caring and sharing on every occasion.

"He was there like all the time like on birthdays and Christmas, buy for me

pencils colours, papers to draw. He really showed me how to draw the things." (Participant 7, p.3)

A family woman

This code was evolved from narratives suggesting that the deceased was the central figure in the family, providing love and care to everyone.

> "She was like the head of the family, very religious, always talk you about right and wrong. If wrong, she'd let you know, a very good hearted woman. Always wanted to help the family, she was a family woman, very lovely, yea." (Participant 23, p.1)

Drug addicted

This code was derived from the description suggesting the deceased was drug addicted just before the death.

> "It's a really long story because she met a boy and she got into very bad group of friends and she became really drug addicted too. My mother started to hate her." (Participant 3, p.3)

Phase 2

In Phase 2 I have condensed those detailed codes into more inclusive and fewer themes that describe participants' bereavement experience. In this analysis, seven general themes were found for the Self as they appeared in the past, three themes for the Self as they appeared in the present and five themes for the deceased. Grouping was conducted based on commonalities between the detailed codes identified in Phase 1.

For example, in Self-past the more general theme *Self is suppressing feelings* was evolved from the interlinked codes: *suppressing grief, avoiding to talk, couldn't cry*, and *hurting*. It was evident from those codes that they all described how the self was trying to hide and suppress negative emotions and distress. The theme *Self has somatic reactions* was the common result of codes such as *tearful, stopped eating, getting ill*, and *having a headache.* These codes were linked to reactions of somatisation of distress. On the other hand, the theme *Self has psychological difficulties* evolved from codes suggesting psychological difficulties such as *declining in school performance, having psychological problem*, and *insecure.*

The theme *Self is seeking contact with the deceased* evolved from codes such as *seeking, dreaming, regularly visiting grave*, and *turning to deceased in bad times* while the theme *Self cannot understand death* came from the codes *having little understanding of death* and *having late realization of loss and disbelieving.* Finally, the theme *Self is consumed* evolved from the codes *having a sense of disappearance* and *empty/vague*, while *t*he theme *Self feels positive* derived from the code *getting matured*.

Table 3.4

Themes describing the past Self according to attachment style

Codes	**General Themes**	**FREQUENCY OF OCCURANCE**			
		Secure	**Preoccupied**	**Dismissing**	**Fearful**
Suppressing grief	**Self is suppressing feelings**	2	2	3	1
Avoiding to talk		1	-	2	3
Couldn't cry		-	1	1	-
Hurting		-	2	-	1
	Total Frequency	**3**	**5**	**6**	**5**
Tearful	**Self has somatic reactions**	2	2	5	4
Stopped eating		-	-	1	1
Getting ill		-	1	1	-
Having headache		-	1	-	-
	Total Frequency	**2**	**4**	**7**	**5**
Declining in school performance	**Self has psychological difficulties**	1	3	1	2
Having psychological problem		1	2	1	1
Insecure		-	-	1	-
	Total Frequency	**2**	**5**	**3**	**3**

Seeking	**Self is seeking contact with deceased**	2	2	-	-
Dreaming		-	2	-	1
Regularly visiting grave		-	-	1	-
Turning to deceased in bad times		-	2	-	-
	Total Frequency	**2**	**6**	**1**	**1**
Having little understanding of death	**Self cannot understand death**	1	1	-	-
Having late realization of loss		1	2	-	1
Disbelieving		-	1	-	3
	Total Frequency	**2**	**4**	**0**	**4**
Having a sense of disappearance	**Self is consumed**	-	1	-	-
Empty/vague		-	2	-	-
	Total Frequency	**0**	**3**	**0**	**0**
Getting mature	**Self feels positive**	-	-	2	-
	Total Frequency	**0**	**0**	**2**	**0**

Moreover, different general themes for the Self as described at the present also came from codes with common elements. The theme *Self wishes closeness* had been evolved from codes *missing, remembering, still talking about, wishing the deceased to be alive, keeping things as memorial, visiting graves, having need in bad times, giving same name to daughter, having memories in head, thinking*

about good time together, and *cannot forget.* The theme *Self is in peace* came from integrating the interlinked codes *feeling happy with memory, having change in sadness, having patience, strong, relaxing in temple*, and *valuing things more.* Finally, the theme *Self is still affected* evolved from the codes *having same feelings, fear of getting close to others, still crying, feeling sorry, lonely, avoiding visit deceased's house, cannot drag her out, getting depressed whenever think*, and *idealizing the deceased.*

Table 3.5

Themes describing the current Self according to attachment style

Codes	**General themes**	**FREQUENCY OF OCCURANCE**			
		Secure	**Preoccupied**	**Dismissing**	**Fearful**
Missing	**Self**	6	6	6	6
Remembering	**wishescloseness**	6	6	6	6
Still talking about		2	3	5	3
Dreaming		1	4	-	-
Wishing the deceased to be alive		-	2	1	2
Keeping things as memorial		1	1	1	-
Visiting grave		1	-	-	-
Having need in bad times		-	-	1	-
Giving same name to daughter		-	-	1	-

Having memories in head		1	-	-	1
Thinking about good times together		-	-	2	1
Cannot forget		-	1	1	-
	Total Frequency	**18**	**23**	**24**	**19**
Feeling happy with memory	**Self is in peace**	6	3	4	3
Having change in sadness		4	3	4	1
Having patience		1	1	-	-
Strong		3	2	1	-
Relaxing in temple		2	1	-	-
Valuing things more		-	-	-	2
	Total Frequency	**16**	**10**	**9**	**6**
Having same feelings	**Self is still affected**	2	2	2	4
Fear of getting close to others		-	1	1	2
Still crying		1	-	2	-
Feeling sorry		1	-	1	1
Lonely		1	-	-	-
Avoiding visit deceased's house		-	1	-	1

Cannot drag her out	-	1	-	-
Getting depressed whenever think	-	1	-	1
Idealizing the deceased	-	2	1	-
Total Frequency	**5**	**8**	**7**	**9**

More general themes that describe the deceased also identified. The first was *deceased was supportive/emotionally close* being evolved from the codes *supportive, caretaker, loving, helpful* and *close.* The second theme *deceased had positive social attributes* came from the codes *nice ,friendly, had a good sense of humour, good behaviour, had patience, honest, outing and stuff, best person, wonderful person, present in all events, smiling face, aback child* and *sweet boy.* The third theme *deceased had leadership qualities* was the common thread of the codes *fatherly figure, guide, a family woman, inspiration,* and *indirect impact.* The theme *deceased was vulnerable* evolved from the codes *sudden illness, long illness, suicide* and *drug addicted* while the theme *deceased was competent* included the codes *disciplined, taught violin, taught drawing, taught religion, educated* and *business minded.*

Table 3.6

Adult attachment style, separation anxiety and parental care and parental overprotectionThemes describing theOther (deceased) according to attachment style

Codes	General Themes	FREQUENCY OF OCCURANCE			
		Secure	Preoccupied	Dismissing	Fearful
Supportive	Deceased was supportive/emotionally close	3	5	3	4
Caretaker		2	3	3	3
Loving		1	3	4	4
Helpful		1	1	-	2
Close		2	1	1	2
	Total Frequency	**9**	**13**	**11**	**15**
Nice	Deceased had positive social attributes	3	3	4	1
Friendly		4	1	3	3
Had a good sense of humour		-	2	-	3
Good behaviour		-	1	-	1
Had patience		-	1	-	-
Honest		-	1	-	1
Outing and stuff		-	-	2	1
Best person		-	1	1	-
Wonderful person		-	1	1	-
Present in all events		-	2	-	-
Smiling face		1	-	-	1
Aback child		1	-	-	-
Sweet boy		2	-	-	-
	Total Frequency	**11**	**13**	**11**	**11**
Fatherly figure	Deceased had leadership qualities	1	5	4	2
Guide		1	3	2	1
A family woman		-	1	-	-
Inspiration		1	1	-	-
Indirect impact		-	-	1	-
	Total Frequency	**3**	**10**	**7**	**3**

Sudden illness	Deceased	was	1	1	-	4
Long illness	vulnerable		-	1	4	1
Suicide			1	1	-	-
Drug addicted			1	-	-	-
Total Frequency			**3**	**3**	**4**	**5**
Disciplined	Deceased	was	-	1	1	-
Taught violin	competent		-	-	1	-
Taught drawing			-	1	-	-
Taught religion			-	1	-	-
Educated			-	1	-	-
Business minded			-	1	-	-
Total Frequency			**0**	**5**	**2**	**0**

Discussion

A primary goal of Study 1 was to explore if people with different attachment styles provide different narratives about their childhood bereavement. This study provided evidence that this was so. As retrospective interviews may not give an exact account of events, my main concern was not with what actually happened but how an individual remembered their childhood bereavement. A number of differences between narratives of individuals with different attachment styles were found, in agreement with the attachment literature.

Firstly, in relation to themes of the past Self, the theme *Self has somatic reactions* were stronger among individuals with dismissing and fearful attachment styles than individuals with a secure or a preoccupied style. These findings are consistent with previous research suggesting that both dismissing and fearful styles are defined by attachment avoidance (Bartholomew**,** 1990). Further, a research study has shown that childhood trauma has a great impact on adult age somatisation by developing an insecure adult attachment style (Waldinger, Schulz, Barsky, & Ahern, 2006).

Moreover, the theme *Self is seeking contact* appeared more prevalent among individuals with preoccupied attachment style than among individuals with secure, dismissing, or fearful styles. Previous studies support these findings and show that both dismissing and fearful attachment styles are defined by attachment avoidance (Bartholomew**,** 1990). Moreover, preoccupied (or anxious) attachment has been linked with an excessive need for contact and closeness, including closeness with the deceased. Bartholomew and Horowitz (1991) suggested that adults with a preoccupied attachment style tend to report negatively about their caregivers who appear inconsistent in responding to their child's needs. Preoccupied individuals tend to think of themselves as unlovable and of others as unavailable. They are clingy and observant, continuously trying to get support from the others.

The theme *lack of understanding of death* appeared stronger in individuals with fearful and preoccupied attachment styles. Research explains the findings and suggests that confusion and cognitive disorganisation are prevalent in fearful/disorganised individuals (Reis & Grenyer, 2004). They use defensive strategies to exclude painful material and their capacity to contain pain is restricted due to frightening experiences with caregivers – abuse, neglect, and loss. On the other hand, preoccupied individuals may be reluctant to represent their loved ones as dead as that may deepen their feelings of loneliness, helplessness, and vulnerability and make the experience unbearable.

The theme *Self is consumed* seemed to be more prevalent in individuals with preoccupied attachment style. Previous literature is consistent with this finding suggesting that individuals with preoccupied attachment style are very dependent on their attachment relationships, so when the attachment relation is lost the preoccupied individual feels lost too (Collins & Read, 1994). These individuals are preoccupied with their attachment relationships constantly

thinking about them and worrying that they may not return.

The theme *Self is suppressing feelings* appeared to be more prevalent among individuals with all insecure attachment styles compared to the secure. This finding is consistent with the previous studies suggesting that individuals using avoidant attachment strategies (deactivation) exclude attachment-related concerns, primarily negative feelings, from consciousness (Dozier & Kobak, 1992). Avoidant individuals have shown suppression of feelings of separation from their current partner in an experimental setting (Fraley & Shaver, 1997). These individuals suppress the negative aspects of their attachment relationships and often report idealized relationships with an attachment figure; they do not fully recall memories related to attachment, and minimize the importance of inter-dependence.

Moreover, those high in anxiety (preoccupied and fearful) also suppress feelings of bereavement as acknowledging those feelings would make them more vulnerable and helpless. Attachment anxiety has been associated with the activation of negative self-depiction and constant feelings of separation (Mikulincer, Dolev, & Shaver, 2004).

Secondly, in relation to the current experience of the Self, the theme *Self is in peace* appeared stronger among individuals with a secure attachment style the most. Studies show that individuals with a secure attachment style are more likely to move on in life and liberate themselves from prolonged grief. They experience less distress while going through bereavement process than the individuals who are insecurely attached (Parkes, 2006).

Moreover, the theme *Self wishes closeness* was particularly strong in individuals with dismissing and preoccupied attachment styles. Previous literature suggests that dismissing individuals are more independent and interpersonally withdrawn

and have a reserved manifestation of affection and grief (Parkes, 2006). This may be the reason they feel less threatened now to approach emotionally someone who is dead compared to when they were alive. These dismissing narratives are particularly noteworthy as a similar past Self theme (*Self is seeking contact with the deceased*) was very weak among the dismissing. It may be that while the loss was recent the dismissing still used their avoidance defences against interpersonal closeness, while after many years the can feel safe from "too much" closeness and they can express more easily their need for emotional closeness. Moreover, there was no change for the preoccupied wanting closeness both now and then.

Moreover, the *Self is still affected* theme is weaker among the secure and stronger among the fearful and the preoccupied. This may be because after so many years those high in attachment anxiety (preoccupied, fearful) are still affected, still may have not completed their mourning properly. On the other hand, the secure have been able to have closure. According to research, securely attached adults are less distressed by bereavement and adopt positive coping style (Parkes, 2006; Schmidt, Nachtigall, Wuethrich-Martone, & Strauss, 2002), while the insecurely attached, particularly those high in anxiety, appear clingy and show a lasting reaction to loss.

Finally, in relation to representations of the deceased, the theme *deceased was supportive* was more prevalent in individuals with fearful attachment style and less prevalent among the secure. Previous literature suggests that individuals with a fearful attachment style can experience the positive aspects of the other more freely when there is no danger of rejection (Reis & Grenyer, 2004). On the other hand, the securely attached acknowledge positive aspects of current relationships freely and have no need to dwell in the past.

The other themes about the deceased were *had leadership qualities*, was *competent*, and *positive social attribute*. These themes were particularly strong among the preoccupied, may be because the preoccupied had the need to feel protected by and be depended on powerful others. Also, research shows that preoccupied individuals tend to exaggerate their close relationships (Shaver & Clark, 1994).

Limitations of Study 1

In the current study, the first limitation is the retrospective nature of the interview accounts. Retrospective accounts are based greatly on the memory of participants and such a memory may not be accurate. Research suggests that recall memory is limited, although research indicates that emotional memories are more accurate than non-emotional ones (Seifert, 2012). Nonetheless, researchers argue that retrospective accounts are valid methods to assess previous experiences (Melchert & Sayger, 1998). The aim of the present study was not to identify accurate events but to map the subjective experience of participants and how that experience relates to attachment style. In other words, what participants say happened may or may not be accurate but this is irrelevant for the purposes of the study. What the study is interested in is how participants subjectively experience and reconstruct the events.

The second limitation in the current study was lack of second rating of the interview transcripts due to time and resource limitations. Inter-rater reliability is a well-known process in qualitative research when data is analysed by comparison (Armstrong, Gosling, Weinman, & Martaeu, 1997). To limit rater biases to an extent, in the current study my supervisor followed my work closely and challenged me in various aspects of the analysis.

In this chapter, Study 1 was presented. This was a qualtitative study involving

university students who had experienced the loss of a loved one in childhood. Participants were classified into one of four attachment styles, using the Relationship Questionnaire (Barthoomew & Horowitz, 1991). Then they were interviewed on their bereavement experience. Thematic analysis of the inerviews suggested that particiants with different attachment styles generated different accounts of their bereavement experience.

CHAPTER FOUR
STUDY TWO

In Study 1 it was found that adults with different attachment styles generate different narratives of their childhood bereavement experience. As was discussed above, this finding was consistent with previous research supporting a link between adult attachment style and the experience of bereavement (Meier, Carr, Currier, & Neimeyer, 2013; Stroebe, 2002). Study 1, however, did not provide explicit links between adult complicated grief, adult attachment style, and childhood experience. Such links were assumed but were not directly assessed, although the above literature suggests that they exist. The aim of Study 2 was to clarify the relationship between quality of parental care and separation anxiety in childhood, adult attachment style, and complicated grief in adulthood. That would suggest a link between insecure attachment in childhood, unresolved loss in childhood, insecure attachment in adulthood, and unresolved loss in adulthood.

Study 2 explored one research question (what are the best predictors of adult complicated grief among indices of parental care) and tested eight research hypotheses:

1. Complicated grief would be positively related to parental protection, separation anxiety, adult attachment avoidance, and adult attachment anxiety.
2. Complicated grief would be negatively related to parent care.
3. Adult attachment style (both anxiety and avoidance) would mediate the link between paternal care (maternal and paternal) received in childhood and complicated grief in adulthood.

4. Adult attachment style (both anxiety and avoidance) would mediate the link between parental overprotection (both maternal and paternal) received in childhood and complicated grief in adulthood.
5. Adult attachment style (both anxiety and avoidance) would mediate the link between separation anxiety experienced in childhood and complicated grief in adulthood.
6. Separation anxiety in childhood would mediate the link between quality of parental care received in childhood and complicated grief in adulthood.
7. Separation anxiety in childhood would mediate the link between parental overprotection received in childhood and complicated grief in adulthood.
8. Separation anxiety in childhood would mediate the link between the quality of parental bonding in childhood (care and overprotection) and adult attachment (anxiety and avoidance).

Methodology

Research Design

This was a simple correlational study, involving a sample of adults who experienced loss of a caregiver in childhood or adolescence (up to the age of 16). Caregivers were either parents or relatives who acted as caregivers. Complicated grief in adults was the main dependent variable (DV), parental care and parental overprotection were independent variables (IV), and adult attachment anxiety and avoidance were mediators (M). Separation anxiety was tested both as an independent variable (hypothesis 5) and as a mediator (hypothesis 8).

Participants

One hundred and twenty one individuals were recruited from the University of Bedfordshire Luton Campus and the local community of Luton, through social

networks and snowballing. The minimum age of the participants was 18 years and the maximum was 53. The majority of them were female (79.3%), while 20.7% were male. In terms of ethnic background, 37.2% were white, 14.9% were Pakistani, 2.5% were Indian, 9.9% were Bangladeshi, 14.0% were Black African, 3.3% were Black Caribbean, 3.3% were Black Other, 2.5% were Chinese, and 12.4% were from various other backgrounds.

Of the participants, 58.7% were married, 8.3% were in long-term relationships but living in separate households, 28.9% were single, and 4.1% were divorced. In terms of the caregiver lost in childhood, 27.3 % had lost their mother, 40.5% had lost their father, while 32.2% had lost another close relative, usually a grandparent that was either exclusively or very heavily involved in the care of the child. Minimum time since loss was 6 years and maximum time was 36 years.

Measures

Four measures were chosen in this study: the Inventory of Complicated Grief (ICG; Prigerson et al., 1995), the Experience in Close Relationships Questionnaire-Revised (ECR; Fraley, Waller, & Brennan, 2000), the Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979), and the Separation Anxiety Symptom Inventory (SASI; Silove, Manicavasagar, O'Connell, Blaszczynski, Wagner, & Henry, 1993). These are all well-validated and well-used measures as described below.

Inventory of Complicated Grief

The ICG has high internal consistency (alpha = .95) and sufficient test–retest reliability (r = .80) as reported in a sample of bereaved college students (Schnider, Elhai, & Gray, 2007). Similar levels of reliability and validity were also found in studies with bereaved samples, including bereaved parents (Keesee, Currier, & Neimeyer, 2008). Reaction to bereavement and loss is different from

individual to individual. Among common s,ymptoms of bereavement response are depression and anxiety, while traumatic grief involves symptoms such as re-experiencing, avoidance and numbing although post-traumatic disorder symptoms are different (Prigerson et al., 1999). According to Silverman et al. (2001), people develop different emotional reactions to grief and some are affected by traumatic grief related to early life experiences.

Childhood traumas such as death of a parent or abuse produce more vulnerability to traumatic grief, whereas death of a child or other adult trauma seems more associated with later post-bereavement PTSD. Traumatic grief, which has only recently been recognized as a separate disorder, seems often to be associated with worse long-term outcome than either post-bereavement depression or PTSD (Silverman et al., 2000). Although the ICG may be completed at any time following a loss, for ethical reasons it should be completed at least 6 months post-loss (Prigerson & Maciejewski, 2006).

The Inventory of Complicated Grief is a questionnaire with 19 items showing the frequency of response of the experience. It uses a 5-point scale (0–4), ranging from never to always, and 25 is the borderline score. Respondents with ICG scores greater than 25 are significantly more impaired in social, general, menta,l and physical health functioning, and in bodily pain than those with ICG scores less than or equal to 25 (Prigerson et al., 1995).

The concurrent validity of the ICG has been assessed in relation to other scales. ICG total score showed a fairly high association with the Beck Depression Inventory (BDI) total score ($r = 0.67$, $p < .001$), the Texas Revised Inventory of Grief (TRIG) score ($r = 0.87$, $p < .001$), and the Grief Measurement Scale (GMS) score ($r = 0.70$, $p < .001$). Reliability: The internal consistency of the 19-item ICG was high (Cronbach's alpha = .94) (Prigerson et al., 1995). In the current study,

scale reliability was α = .9.

Experience in Close Relationships Questionnaire-Revised

This questionnaire measures two dimensions of adult attachment, avoidance and anxiety, and is described in Study 1 (Method section). In the current study, scale reliability was α = .8 for adult attachment avoidance and α = .9 for adult attachment anxiety.

Separation Anxiety Symptom Inventory (SASI)

This is a 15-item self-report measure that assesses retrospective separation anxiety symptoms in adults. The items are set to assess subjective experience, feelings, and early memories suggesting separation anxiety, and are scored from 0 to 3 on a frequency Likert scale. The authors (Silove et al., 1993) report a strong internal (Cronbach's alpha = .88) and test–retest reliability over 24 months (intraclass correlation coefficient = 0.89). In previous studies, mean transformed SASI scores of 4 or more have been associated with reports of past childhood separation anxiety disorder and/or school refusal, offering some evidence of the concurrent validity of the measure (Manicavasagar, Silove, & Hadzi-Pavlovic, 1998). In the current study, scale reliability was α = .9.

Parental Bonding Instrument (PBI)

This instrument is designed to assess the quality of bonding with mother and father experienced in childhood. The measure is 'retrospective', so adults or older adolescents (over 16 years) complete the measure for how they remember their parents during their first 16 years of life. The scale is divided in two subscales termed Care and Overprotection or 'control', and each needs to be completed for both mother and father separately. There are 25 items referring to each parent, including 12 Care items and 13 Overprotection items. Items are

scored on a 4-point Likert scale (Very like = 3, Moderately like = 2, Moderately unlike = 1, Very unlike = 0). Total scores can be generated for each parent, on each dimension as well as total care and total overprotection scores.

Also, based on those scores, parents can be put under one of four quadrants: “affectionate constraint” (high care and high overprotection), “affectionless control” (high overprotection and low care), “optimal parenting” (high care and low overprotection), and “neglectful parenting” (low care and low overprotection). Assignment to “high” or “low” categories is based on the cut-off scores.

The scale has been used with various clinical and non-clinical groups and has been found to have good internal consistency and re-test reliability. It has also been found to have construct and convergent validity and to be independent of mood effects. In the current study, scale reliability was $\alpha = .8$ for all four subscales.

Procedure

I was fully aware of the sensitivity of my topic and therefore I approached the whole research process with extreme caution, as described in Study 1. For this study university students and colleagues were approached if they had experienced the loss of parent or caregiver.

After informing participants about the nature and aim of the study, written informed consent was obtained and questionnaires were passed on. Participants took about 15-20 minutes to complete them. Most completed and returned the questionnaire to me there and then, but some returned them later. After completion, a debrief form was provided with information about how to contact me, my supervisor, and local bereavement and counselling services should they

feel the need to do so. The data collection process was slow and with occasional hurdles as some participants took a long time to agree to participate, others left the questionnaires half-completed and needed to be chased, and others lost the questionnaires and had to be provided them again.

Ethical Issues in the Study

It is the utmost duty of a researcher to promote the respect and autonomy of the participants. I was fully aware that my research involved a very sensitive topic therefore I approached the whole research process, particularly data collection with extreme caution. I applied the BPS ethics code throughout and I attended meetings with my supervisors so that I got training to administer data collection properly. As the deceased would be expected to be very close to the participant, the participants might be bereaved and be therefore in a potentially vulnerable position. To minimize potential distress in them I took the following additional measures:

a. I allowed enough time for participants to think carefully if they were certain they wished to participate in the study – I allowed three days between first participant contact and questionnaire delivery.
b. Prior to the study commencing, I asked if they suffered from a serious physical or psychiatric illness, had responded badly to bereavement, or were experiencing any other kind of distress. If they did, they were excluded from the study.
c. I was vigilant throughout the study for any signs of participant distress or hesitation. If I observed such signs or was asked directly by the participant I interrupted questionnaire completion, postponed it, or cancelled it.

d. I provided information about the study in writing and verbally and took a written consent from them. Participants were reassured that information would be anonymous and strictly confidential and all data would be kept safe.
e. Although I was expecting participants not to be under serious distress, mild distress is possible even later after questionnaire completion. To address that I provided them with the contact details of the local bereavement/counselling organizations including child mental health services. Also, they were given my contact details and those of my supervisor for any questions or comments they might have.

In designing and conducting my research I had reflected on the methodological and ethical issues in bereavement research discussed in the relevant literature, for example, by Stroebe, Stroebe, and Schut (2003). Such issues involved the benefits and limitations of using quantitative and qualitative methods in research with those that have been bereaved. Also, I recognized that those who have been bereaved may not admit to themselves or the interviewer feelings of well-being as this goes against social norms of grieving (Stroebe et al., 2003).

Results

In a preliminary analysis participants who had lost a parent did not differ in any of the study variabes from those who had lost another caregiver (Wilks = .93, $F_{6,101} = 1.12$, $p = .357$).

Hypothesis 1 and Research Question

To address hypothesis 1 I ran bivariate correlation analysis. The results showed that as predicted, complicated grief was positively correlated to mother overprotection, father overprotection, separation anxiety, and adult attachment

anxiety, while it was not correlated to attachment avoidance. Results also showed that, as predicted, complicated grief was negatively correlated with both mother care and father care (see Table 4.1).

Table 4.1

Correlations between study variables

	1 Compl. Grief M=25.8 SD=15.0	2	3	4	5	6	7
2. Mother Care M=17.60,SD=8.75	-.22*	1					
3. Mother Overprotection M=19.65,SD=4.75	.26**	-.25**	1				
4. Father Care M=18.66,SD=8.03	-.23*	.21*	-.24**	1			
5. Father Overprotection M=18.47,SD=5.65	.21*	-.41**	.65**	-.27**	1		
6. Separation Anxiety M=22.35,SD=13.52	.20*	.16	.06	.01	-.02	1	
7. Attachment Anxiety M=63.05,SD=23.30	.34**	-.31**	.34**	-.26**	.44**	.05	1
8. Attachment Avoidance M=65.15,SD=19.05	.13	-.35**	.32**	-.22*	.55**	-.01	.54**

Notes: ** = probability below .01 * = probability below .05

Having inspected the bivariate correlations involving complicated grief, I explored the research question by running a Hierarchical multiple regression. Complicated grief was put as the DV, mother care, mother overprotection, father

care, father overprotection, separation anxiety, adult attachment anxiety, and adult attachment avoidance were entered as predictors. The results showed that separation anxiety and adult attachment anxiety were the only independent predictors in the model.

Table 4.2

Multiple Regression between Variables

Model	Beta	T	Sig.
(Constant)		2.009	.047
Mother Care	-.160	-1.663	.099
Mother Overprotection	.136	1.192	.236
Father Care	-.125	-1.408	.162
Father Overprotection	-.027	-.200	.842
Separation Anxiety	.204	2.380	.019
Adult Attachment Avoidance	-.128	-1.162	.248
Adult Attachment Anxiety	.280	2.687	.008

To address all remaining hypotheses, I utilised linear regression to test for mediation effects. To achieve that, I took the following steps, as suggested by Baron and Kenny (1986). First, I confirmed that the three regressions between the three variables involved each time were significant – that is, between IV and M, M and DV, and IV and DV. If any of those effects were not significant, no mediation was observed and the process finished here. If all effects were significant, I proceeded to Step 4. In Step 4, if the effect of the IV on the DV became non-significant or the p value was changed after controlling for the

mediator, mediation was suspected and then I proceeded to the final step, conducting the Sobel test using the MedGraph software. This final test indicated if there was mediation and if the mediation was partial or full. Full mediation was expected when the controlled effect of the IV had become non-significant.

Hypothesis 3

Testing hypothesis 3, it was found that the regressions between mother care (IV) and adult attachment anxiety (M) (b = -.31, p = .001), mother care (IV) and complicated grief (DV) (b = -.23, p = .014), and adult attachment anxiety (M) and complicated grief (DV) (b = .34, p = .000) were significant. Therefore the next step was conducted and effects of the mediator (adult attachment anxiety) were controlled for. It was found that the effect of the IV on the DV became non-significant (b = -.13, p = .154), strongly suggesting full mediation. The Sobel test confirmed that adult attachment anxiety fully mediated the effects of mother care on complicated grief (Sobel z-value = -3.33, p = .001).

The process was repeated with attachment avoidance as mediator and it was found that the regressions between mother care (IV) and adult attachment avoidance (M) (b = -.35, p = .000) and between mother care (IV) and complicated grief (DV) (b = -.23, p = .014) were significant, but the effect of adult attachment anxiety (M) on complicated grief (DV) was not (b = .13, p = .144). Therefore, the process stopped there and no mediation was recorded.

Moreover, the regressions between father care (IV) and adult attachment anxiety (M) (b = -.26, p = .004), father care (IV) and complicated grief (DV) (b = -.23, p = .012), and adult attachment anxiety (M) and complicated grief (DV) (b = .30, p = .001) were all significant. When I controlled for the effects of the mediator (adult attachment anxiety) the effect of the IV on the DV became non-significant (b = -.15, p = .096). The Sobel test confirmed that adult attachment anxiety fully

mediated the effects of father care on complicated grief.

On the other hand, the regressions between father care (IV) and adult attachment avoidance (M) (b = -.22, p = .018) and father care (IV) and complicated grief (DV) (b = -.23, p = .012), and adult attachment avoidance (M) and complicated grief (DV) (b = .12, p = .135) were not all significant so there was no mediation and the process finished here.

Hypothesis 4

Moreover, the regressions between mother overprotection (IV) and adult attachment anxiety (M) (b = .34, p = .000), mother overprotection (IV) and complicated grief (DV) (b = .26, p = .004), and adult attachment anxiety (M) and complicated grief (DV) (b = .34, p = .000) were significant. Again, when I controlled for the effects of the mediator (adult attachment anxiety), the effect of the IV on the DV became non-significant (b = .16, p = .080) and the Sobel test suggested a full mediation (Sobel z-value = 2.47, p = .01). On the other hand, the regressions between mother overprotection (IV) and adult attachment avoidance (M) (b = .32, p = .000) and mother overprotection (IV) and complicated grief (DV) (b = .26, p = .004) were significant, but the effect of adult attachment avoidance (M) on complicated grief (DV) (b = .13, p = .144) was not significant. No mediation was recorded.

The regressions between father overprotection (IV) and adult attachment anxiety (M) (b = .44, p = .000), father overprotection (IV) and complicated grief (DV) (b = .21, p = .021), and adult attachment anxiety (M) and complicated grief (DV) (b = .34, p = .000) were allsignificant. When I controlled for the effects of the mediator (adult attachment anxiety) I found that the effect of the IV on the DV became non-significant (b = .07, p = .46) and the Sobel test confirmed that adult attachment anxiety fully mediated the effects of father overprotection on

complicated grief (Sobel z-value = 2.76, p = .01). On the other hand, attachment avoidance did not mediate the relationship between paternal overprotection and complicated grief. The regressions between father overprotection (IV) and attachment avoidance (M) (b = .55, p = .000), and father overprotection (IV) and complicated grief (DV) (b = -.21, p = .021) were significant, but the effect of attachment avoidance (M) on complicated grief (DV) (b = .13, p = .144) was not.

Hypothesis 5

Testing hypothesis 5, the regressions between separation anxiety (IV) and adult attachment anxiety (M) (b = .05, p = .593) was not significant although the effect of separation anxiety (IV) (b = .20, p = .031) and adult attachment anxiety (M) (b = .34, p = .000) on complicated grief were. Therefore no mediation was observed. No mediation of attachment avoidance was observed either on that link. The regressions between separation anxiety (IV) and adult attachment avoidance (M) (b = -.01, p = .913), and adult attachment avoidance (M) on complicated grief (DV) (b = .13, p = .144) were non-significant, while the effect of separation anxiety (IV) on complicated grief (b = .20, p = .031) was.

Hypothesis 6

Testing hypothesis 6, the regression between total care (IV) and separation anxiety (M) (b = .12, p = .194) was non-significant, although the effects of total care (IV) (b = -.29, p = .001) and separation anxiety (M) (b = .20, p = .031) on complicated grief were significant. As a result no mediation was recorded. When the effects of maternal (b = .17, p = .070) and paternal care (b = 08, p = .685) on separation anxiety were examined separately these were also non-significant.

Hypothesis 7

Similarly, testing hypothesis 7, the regression between total overprotection (IV) and separation anxiety (M) (b = .019, p = .840) was non-significant but the effects of total overprotection (IV) and (b = .30, p = .010) and separation anxiety (M) (b = .20, p = .031) on complicated grief were significant. However, no mediation could be evidenced in this case either. When the effects of maternal (b = .06, p = .514) and paternal overprotection (b = .5, p = .780) on separation anxiety were examined separately these were also non-significant.

Hypothesis 8

Testing hypothesis 8, it was found that the pathways between separation anxiety (M) and maternal care (IV) (b = .17, p = .069) and separation anxiety and paternal care (IV) were not significant (b = .03, p = .762), so there was no evidence for a mediational effect. Similar findings were obtained in relation to parental overprotection. The effects of maternal (b = .06, p = .514) and paternal (b = .03, p = .696) overprotection on separation anxiety were not significant, so no mediation effect on the link between parental bonding and adult attachment style was recorded.

Discussion

Study 2 identified the attachment correlates and independent predictors of adult complicated grief. The latter correlated positively with parental overprotection, separation anxiety, and adult attachment anxiety and negatively with parental care. Separation anxiety and attachment anxiety were the only independent predictors of complicated grief. The study also tested six mediational hypotheses. Adult attachment anxiety, but not avoidance, mediated the link between parental care and overprotection and complicated grief. This was true for

maternal and paternal bonding. Results also suggested that adult attachment style did not mediate the link between separation anxiety in childhood and complicated grief in adulthood and separation anxiety did not mediate the link between parental bonding and complicated grief. Finally, separation anxiety did not mediate the link between parental bonding and adult attachment style.

Discussion of Hypotheses 1 and 2

The findings regarding hypothesis 1 and hypothesis 2 were consistent with previous research. Firstly, findings indicated that adults with overprotective parents experienced greater complicated grief. Parental control and protection is an important parenting dimension (Wood et al., 2003). Research suggests that individuals who as adults suffer from social anxiety recall in their retrospective accounts childhood experiences with parents as overprotective, less emotional, and rejecting (Arrindell, Emmelkamp, Monsma, & Brilman, 1983; Arrindell et al., 1989). Also, adults with high levels of anxiety and depression reported that their mothers had been less caring and more overprotective (Parker, 1979, 1981, 1990). Parker (1981) found that adults with "anxiety neurosis" remembered their fathers as low in care and higher in overprotection as compared to participants in a control group, while high paternal overprotection has also been related to a looming-maladaptive cognitive style (Riskind, Williams, Altman, Black, Balaban, & Gessner, 2004).

Moreover, studies suggest that parental overprotection may be involved in the intergenerational transmission of complicated grief. Cote-Arsenault (2003) found that mothers who lost their child in pregnancy were very overprotective towards the subsequent child. This finding was also consistent with earlier research (Cain & Cain, 1964; Pozanski, 1972) suggesting that overprotection in bereaved parents may be an unconscious attempt to prevent another loss. Hudson and Rapee (2001) argue that overprotection increases internalizing problems in children and

develops dependency on the parents, while Parker, Tupling, and Brown (1979) emphasize that parental overprotection is a great hurdle in the child's personal growth, autonomy, and independence.

Moreover, the present findings also showed that individuals who had experienced separation anxiety and relatively poor parental care during childhood were more vulnerable to complicated grief. This is also consistent with previous research indicating that disruptions in the attachment bond in childhood is linked with complications in the grieving process in adulthood. A secure attachment in childhood can provide a secure base from which the painful feelings of loss can be explored and understood. Attachment research suggests that a secure attachment relationship helps the child develop the capacity to undertand the state of mind of self and others (Fonagy et al., 1993). On the other hand, Silverman and colleagues (2001) report that neglectful and abusive experiences in childhood are closely associated with complicated grief among widows and widowers. Moreover, Vanderwerker, Jacobs, Parkes, and Prigerson (2006) found that in a sample of bereaved individuals, childhood separation anxiety was significantly associated to complicated grief. Research also suggests that attachment anxiety is closely associated to chronic grief, as anxiously attached individuals are more vulnerable to such grief compared to securely and avoidant attached persons (Fraley & Bonanno, 2004).

Discussion of research question

The present findings showed that separation anxiety and adult attachment anxiety were the only independent predictors of complicated grief. According to Bowlby and the attachment theorists, separation anxiety is a central aspect of attachment security (Bowlby, 1973; Sroufe, Carlson, Levy, & Egeland, 1999). The literature on attachment and bereavement suggests that loss of the caregiver increases the risk of insecure attachment as the child may feel unprotected and

left with high separation anxiety (Bowlby, 1961; Parkes, 1972). Such experiences may lead to complicated bereavement. The present findings support those arguments. Separation anxiety and fear of abandonment are central characteristics of the attachment anxiety dimension in adulthood. According to attachment researchers (Mikulincer & Shaver, 2003), attachment anxiety in adults is rooted in inconsistent parenting in which the child doubts if the caregiver will return again. That increases the child's vulnerability in the case of actual parental loss through death, as it is supported in previous studies (Fraley & Bonanno, 2004) and the present research.

Discussion of Hypotheses 3, 4, and 5

The findings of the analysis suggested that adult attachment anxiety fully mediated the effects of paternal care and overprotection on adult complicated grief. Full mediation suggests that children with poor parental care developed complicated grief in adulthood only because they also developed an anxious attachment style. This finding is consistent with the research discussed above highlighting the link between complicated grief and attachment anxiety. Low parental care and high parental overprotection received in childhood predispose an individual to attachment anxiety – that is, a sense of being unloved and undervalued and a fear of rejection and abandonment. Those who maintain such a pattern into adulthood are less likely to resolve the loss of caregiver in childhood.

Anxiously attached adults have difficult relationships with others, so a source of support that could help towards resolution is not properly used. Anxiously attached women reported grater emotional distress and inconsistency in their interpersonal relationships (Meyer et al., 2005) and more instability in couple relationships (Arriaga, Reed, Goodfriend, & Agnew, 2006), and less support, positivity and disclosure in peer relationships (Tidwell et al., 1996). Moreover,

according to Kho, Kane, Priddis, and Hudson (2015), grieving individuals with higher attachment anxiety report greater emotional responses and higher non-acceptance. Moreover, Sandberg, Suess, and Heaton (2010) report that adult attachment anxiety partially mediated the relationship between a variety of traumatic events and post-traumatic symptomatology.

Attachment avoidance did not mediate the link between parental bonding and complicated grief. Although an insecure style, the avoidant style appears to be more adaptive than anxious attachment – avoidant individuals are self-sufficient, generally competent, and cope better with difficulties (Shaver & Mikulincer, 2002). Avoidant individuals keep their attachment system under-activated and that often increases their capacity to adapt more effectively to life challenges than the anxiously attached.

According to the present findings, neither attachment style mediated the link between separation anxiety and complicated grief. In other words, separation anxiety experienced in childhood may lead to unresolved grief in adulthood regardless of whether the adult has developed an anxious or avoidant attachment style. This finding is consistent with attachment researchers supporting the importance of childhood separation anxiety as a predisposition towards unresolved grief (Bowlby, 1961; Parkes, 1972).

Discussion of Hypotheses 6, 7, and 8

Finding suggested that separation anxiety experienced in childhood did not mediate the link between parental bonding and complicate grief or between parental bonding and adult attachment style. In other words, the effect of parental bonding and adult attachment style would lead to complicated grief irrespective of separation anxiety experienced in childhood. In fact, separation anxiety as measured by the current questionnaire was unrelated to parental

bonding and adult attachment in this study. This finding was surprising, but indicates the complexity of measuring different aspects of attachment relationships using different measures. This complexity has been highlighted many times in the attachment literature (e.g. Crowell, Fraley, & Shaver, 2008).

In this chapter, Study 2 was presented. Study 2 was conducted with a sample of adults who had lost a caregiver in childhood. According to the findings, complicated grief in childhood had a positive correlation with separation anxiety, parental overprotection, and attachment anxiety, and a negative correlation with parental care. Separation anxiety and attachment anxiety were the only independent predictors of complicated grief. Finally, attachment anxiety fully mediated the effects of parental care and overprotection on complicated grief. Findings are in agreement with previous research and suggest that suboptimal bonding with parents in childhood leads to complicated grief in adulthood only through attachment anxiety.

Limitations of Study 2

The main limitations of this study refer to its correlational design, conveneniece sample, and use of self-report measures. Causal relationships in a correlational study are unclear, as traumatic and complicated loss may have an impact on parental bonding and separation and bereavement. The generalisability of the findings is limited in convenience samples as different ethinic and socio-economic groups may differ in relevant variables. Moreover, although the questionnaires used have been thoroughly validated, self-report measures always include the possibility of social desirability bias. Finally, this study did not look specifically at the effects of bonding with the deceased parent, when that was relevant, but assessed the overall bonding with each parent. Furture research may consider these more specific effects and their importance.

In this chapter a correlational study was presented. The study employed 121 participants who experienced loss of caregiver in childhood. Four established questionnaires were used: Inventory of Complicated Grief (ICG; Prigerson et al., 1995), Experience in Close Relationships Questionnaire-Revised (ECR; Fraley, Waller, & Brennan, 2000) Separation Anxiety Symptom Inventory (SASI; Silove et al., 1993) and Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979). The results showed that complicated grief was related to parental care and overprotection, separation anxiety, and adult attachment style. Anxious attachment style fully mediated the effects of parental bonding on complicated brief.

CHAPTER FIVE
STUDY THREE: HYPOTHESES, METHOD, AND RESULTS

In Study 1, thematic analysis suggested that adults who had been bereaved as children present varied accounts of their bereavement experience according to their adult attachment style. Using quantitative methods, Study 2 suggested that among adults who were bereaved of a caregiver in childhood, complicated grief in adulthood was related to the quality of the parental care they received. Poor parental care in childhood lead to complicated grief in adulthood only if the individuals had developed an anxious attachment style. In Study 3, the intergenerational transmission of complicated grief is investigated and the role of parental attachment style and parenting style is clarified.

Research hypotheses

Study 3 aimed to address the following research hypotheses:

1. According to hypothesis 1, the bereaved children were expected to report more behavioural problems than non-bereaved children.
2. According to hypothesis 2, among the bereaved children, child behavioural problems were expected to have significant positive correlation with both of parent attachment dimensions; parent-complicated-grief, parenting style, duration of bereavement, and closeness with the deceased.
3. According to hypothesis 3, among the bereaved group, children's reaction to bereavement was expected to have significant positive correlation with both of parent attachment dimensions, parent-complicated-grief, parenting style, duration of bereavement, and closeness with the deceased.

4. According to hypothesis 4, both of parent attachment dimensions (anxiety, avoidance) would moderate the link between bereavement status (bereaved, non-bereaved) and child problems (SDQ). It was expected that bereaved children whose parents had relatively high attachment anxiety/avoidance would have more behaviour problems compared to those whose parents have low attachment anxiety/avoidance, while the level of the behaviour problems among non-bereaved children would not be affected by the attachment anxiety/avoidance of their parents.
5. According to hypothesis 5, parent-complicated-grief would moderate the link between bereavement- status and child-problems (SDQ). It was expected that bereaved children whose parents had relatively high unresolved complicated grief would have more behaviour problems compared to those whose parents have low unresolved complicated grief while the level of the behaviour problems among non-bereaved children would not be affected by unresolved complicated grief of their parents.
6. According to hypothesis 6, parenting styles (PS-Laxness, PS-Verbosity, and PS-Overreactivity) would moderate the link between bereavement-status and child-problems (SDQ). It was expected that bereaved children whose parents had relatively high laxness/overreactivity/verbosity would have more behaviour problems compared to those whose parents have low laxness/overreactivity/verbosity, while the level of the behaviour problems among non-bereaved children would not be affected by attachment laxness/overreactivity/verbosity by their parents.
7. According to hypothesis 7, parental attachment avoidance and attachment anxiety would be the strongest predictors of child behavioural problems measured by the SDQ and the CSQ.
8. According to hypothesis 8, both parent attachment dimensions would

moderate the link between parent-complicated-grief and child problems (SDQ and CSQ). It was expected that children, of the parents having unresolved complicated grief who had relatively high attachment anxiety/avoidance, would have more behaviour problems compared to those whose parents who had low attachment anxiety/avoidance, while the level of the child behaviour problems of the parents having unresolved complicated grief would not be affected by attachment anxiety/avoidance of their parents.

9. According to hypothesis 9, both parent attachment dimensions would moderate the link between parenting styles and child problems. It was expected that children, of the parents having laxness/overreactivity/verbosity had relatively high attachment anxiety/avoidance, would have more behaviour problems compared to those whose parents have low attachment anxiety/avoidance while the level of the child behaviour problems of the parents having laxness/overreactivity/verbosity would not be affected by attachment anxiety/avoidance by their parents.
10. According to hypothesis 10, parent-complicated-grief would moderate the link between parenting styles and child problems. It was expected that children of parents having laxness/overreactivity/verbosity who had relatively high unresolved complicated grief, would have more behaviour problems compared to those whose parents who had low unresolved complicated grief, while the level of the child behaviour problems of the parents having laxness/overreactivity/verbosity would not be affected by unresolved complicated grief by their parents.

Methodology

This section describes the research design, participants, procedure, and analysis

of the present study.

Research sesign

This was a correlational study. Behavioural problems in children was the main dependent variable (DV) while bereavement status, parent-complicated-grief, parent attachment dimensions, and parenting styles were treated as independent variables (IV) or moderators. This study aimed to compare differences of behavioural problems between bereaved and non-bereaved children and investigate how parental variables (e.g. a secure or insecure attachment style, parent-complicated-grief, parenting style) may affect children who have experienced bereavement.

Participants

This study was limited to parents (primary caregivers) of children aged 3 to 16 from the local community of Luton. Participants were divided in to two groups: parents of children who had undergone some substantial bereavement (close family member, friend of the child, anyone the child was close with) and the parents of children without such bereavement experience. Either the mother or the father of a child took part, but most participants were mothers as primary caregivers of the children.

Parents of Children with Bereavement Experience

One hundred and thirty-nine parents of the children with experience of bereavement and 101 parents of children without experience of bereavement participated in this study. Parents (mostly mothers and some fathers) were recruited for this study from the local community of Luton (e.g. snowballing, friends, colleagues, and acquaintances). Particularly, four schools, a registered charity, and university students from the Luton area were approached. At the

beginning of the research, five hundred (500) self-report questionnaires were distributed to university students and their acquaintances, and parents in different schools and the community.

The minimum age of the parents was 21 years, and the maximum was 50. The majority of them were mothers (75.5%), while 24.5% were fathers. 56.8% were British nationals, while 43.2% were non-British nationals. In terms of ethnic background 46.0% white, 20.1% were Pakistani, 0.7% were Black Other, 4.3% were Indians, 9.4% were Black Africans, 5.0% were Black Caribbean, 3.6% were Chinese, 5.0% were Bangladeshi and 5.8% were other. Among them 84.9% were married, 8.6% were in relationships, separate household, 2.9% were single, 2.9% were divorced, and 0.7% were separated. In terms of educational background 59.7 % were university students, 20.1% were further education college students, 12.2% A-Level, 5.8% were GCSE, and 2.2% were lower than GCSE qualified. The minimum age of the child was 3 years and the maximum age was 16 years. 92.1% were 4–16 years of group, while 7.9% were 3–4 years of age.

Table 5.1

Descriptive Statistics for the Bereaved-Group

Age (years)	N	Minimum	Maximum
Parent Age	139	21	50
Child Age	139	0	1

Parents of Children without Bereavement Experience

The non-bereaved sample was recruited from the Luton community, particularly from schools, parks, the shopping centre and the university. This group was comparatively easy to approach. The minimum age of the parents was 22 years, and the maximum was 51. The majority of them were mothers (96.0%), while

4.0% were fathers. 83.2% were British nationals, while 16.8% were non-British nationals. In terms of ethnic background 60.4% were white, 12.9% were Pakistani, 1.0% were Indians, 10.9% were Black Africans, 2.0% were Black Caribbean, 4.0% were Bangladeshi and 5.9% were other. Among them 90.1% were married, 8.9% were in relationships, separate household, 1.0% were single. In terms of educational background 51.5 % were university students, 30.7% were further education college students, 5.9% A-Level, 8.9% were GCSE, and 3.0% were lower than GCSE qualified. The minimum age of the child was 3 years and the maximum age was 16 years. 95.0% were 4–16 years of age, while 5.0% were 3–4 years of age.

Table 5.2

Descriptive Statistics for Non-Bereaved Group

Age (years)	N	Minimum	Maximum	Mean	SD
Parent Age	101	22	51	33.79	7.286
Child Age	101	0	1	.05	.218

Measures

Five measures were chosen in this study very carefully for this target group: Child Stress Questionnaire (CSQ; Saxe, 2011), Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), the Parenting Scale (PS; Arnold, 1993), Inventory of Complicated Grief (ICG; Prigerson et al., 1995), and Experience in Close Relationships Questionnaire-Revised (ECR; Fraley, Waller, & Brennan, 2000). CSQ and SDQ were used to measure the child's stress and behavioural symptoms, while ICG, ECR and PS were used to measure parental qualities.

These measures were very carefully selected as they had a proven reliability and

validity record from previous research. Both groups of parents with and without a bereaved child had completed these measures, except the Child Stress Questionnaire that was specific to the bereaved-children group. These measures are described in detail as follows.

Child-Stress Questionnaire (CSDC; Saxe et al., 2003)

The CSDC has shown great reliability and validity in assessing personality, attitudes, beliefs, and academic achievements, and it has a great importance in research (Saxe et al., 2003). The internal consistency reported in other studies was high (Cronbach's alpha = .84) in Saxe et al. (2003) and Cronbach's alpha = .87 in Pelley et al. (2013). The latter developed and also validated the instrument against measures of assessing psychological and social problems and coping in young children and their parents after facing an unexpected pediatric burn-injury.

Child stress questionnaire was used to assess bereaved children as it measures the behavioural and emotional problems in children after a terrifying experience. It shows post-traumatic stress in children reported by an observer, most likely a parent or primary caretaker. To describe the immediate response there are three options: very true, somewhat true, and not true, scoring 2, 1, and 0, respectively. If any child has experienced more than one event, it would be better to choose the most distressing one. Scores were calculated by adding the responses of post-traumatic symptoms. The first part of the questionnaire was to collect descriptive and qualitative information about the circumstances of the traumatic event. This part was not meant to be scored. The second part was to collect quantitative information about the event. The first five items indicated the immediate responses of the child to the event. The Immediate-Response Score was calculated by adding the scores (0, 1, or 2) for these five items.

The remainder of the CSDC assesses 30 different post-traumatic symptoms on five dimensions: 1) Reexperiencing, 2) Avoidance, 3) Numbing and Dissociation, 4) Increased Arousal, and 5) Impairment in Functioning. The score for each dimension is calculated by adding the responses for each item in that dimension. The total Post-Traumatic Symptom Score was calculated by adding the responses for all 30 items.

Internal reliability was calculated based on the data from the bereaved participants (*n* = 139). Among them Cronbach's alpha is .93 for the total 30-item scale while for subscales: CSQ-Immediate-Response, CSQ-Reexperiencing, CSQ-Avoidance, CSQ-Numbing-and-Dissociation, CSQ-Increased Arousal and CSQ-Impairment-in-Function were $\alpha = .73$, $\alpha = .78$, $\alpha = .69$, $\alpha = .78$, $\alpha = .73$ and $\alpha = .68$, respectively. These findings suggested that these subscales were internally consistent in the bereaved sample.

Strength and Difficulties Questionnaire (SDQ; Goodman, 1997)

The SDQ has been used widely in the past decade for screening for psychological and behavioural problems in children in community and clinical samples in different cultures (Goodman, 2001; Goodman, Renfew, & Mullick, 2000; Muris, Meesters, & van den Berg, 2003; Van Widenfelt, Goedhart, Treffers, & Goodman, 2003). It has shown validity in correlation with other signs of emotional, social, and mental disorders (Goodman et al., 2000). SDQ shows concurrent validity and strong correlations with other directions of psychopathology (Becker, Hagenberg, Roessner, Woerner, & Rothenberg, 2004) and construct validity with psychopathology and personal strengths (Muris, Meesters, & van den Berg, 2003). Normally, the SDQ reports about 50% of anxiety disorders in child psychological behaviour (Goodman, 2001).

These questionnaires are used to measure emotional and behavioural problems

in children. These scales emphasize strengths as compared to older scales such as Ruther A and B Scales and put a greater emphasis on strengths. The questionnaire includes 25 items – five subscales of five items each, to assess the different behaviours and emotions of children. Each item has three options, not true, somewhat true, and certainly true. These questionnaires have both teacher and parent versions. These are age specific scales; one is valid for 4–16 years old and the other for 3–4 years old. There is an additional questionnaire to be completed by young people of 11–16 years old as parents sometimes are unaware of their emotions – parent's accounts have more reliability in the case of younger children.

Overall score shows the significant problems in children and adolescence. All items can be divided into subscales for prosocial behaviour (item number 1, 4, 9, 17, and 20), hyperactivity (2, 10, 15, 21, and 25), emotional problems (3, 8, 13, 16 and 24), conduct problems (5, 7, 12, 18, and 22) and peer problems (6, 11, 14, 19, and 23). On the back of each questionnaire there are questions to assess duration of the difficulties and their impact on the child, themselves or others. Participants including, parents, teachers, or children need to know the appropriate use of the questionnaires. The scale takes about 10 minutes to complete. These questionnaires are helpful in screening for low, average, or high scores in the general population but they do not guarantee that high scores necessarily suggest disorder or that low scores indicate no problems at all.

In the present study, the results show that Cronbach's coefficient alpha for the 25-item scale of the SDQ in total is .849 for the bereaved sample and .828 for the non-bereaved. Moreover, for the five subscales among the bereaved sample (*n* = 139), SDQ-Prosocial Scale alpha = .69, SDQ-Hyperactivity alpha = .53, SDQ-Emotional Problem alpha = .68, SDQ-Conduct Problem alpha = .46 and SDQ-Peer-Problem, alpha = .56 while among the non-bereaved sample (*n* = 101) SDQ-

Prosocial Scale alpha = .63, SDQ-Hyperactivity alpha = .44, SDQ-Emotional Problem alpha = .65, SDQ-Conduct Problem alpha = .23, and SDQ-Peer-Problem alpha = .44.

Inventory of Complicated Grief (ICG; Prigerson et al., 1995)

This questionnaire measures complicated grief in a single scale and is described in detail in Study 2 (Method section). In Study 3 the Cronbach's alpha value is .94 for the bereaved sample and .90 for the non-bereaved.

Experience in Close Relationships Questionnaire-Revised (ECR; Fraley, Waller, & Brennan, 2000)

This questionnaire measures the two adult attachment dimensions (avoidance and anxiety) and is described in detail in Study 1 (Method section). In this study, scale reliability for the bereaved sample for 18-item avoidance was α = .88, while for anxiety α = .89. For the non-bereaved sample, reliability for 18-item avoidance was α = .80 and for 18-item anxiety α = .92.

The Parenting Scale (PS; Arnold, 1993)

The Parenting Scale has shown good reliability and internal consistency. Research shows that the Laxness and Overreactivity factors are consistent with the lenient and controlling parenting styles (Baumrind, 1968). Much research exists in which the Parenting Scale is linked to child behaviour problems (Lahey, Moffitt, & Caspi, 2003; Patterson et al., 1992). Data from parents of preschoolers have revealed three factors: Overreactivity, Laxness, and Verbosity, while the internal consistencies were good with Cronbach's alpha of .83, .82, .63, and .84 for Laxness, Overreactivity, Verbosity, and the total score, respectively (Arnold et al., 1993).

The Parenting Scale is a 30-item questionnaire that is scored on a 7-point scale,

where 7 is ineffective score. The low scores indicate good parenting while high scores indicate dysfunctional parenting. There are three subscales of parenting: Laxness (LX), Overreactivity (OR), and Verbosity (VB). (NF) stand for those items which are not on any factor. There are some reverse keys, if the ideal scoring is on the left (L), the left side is scored 1. If the ideal side is on the right side, the right side is scored 1 rather than 7. Thus, the 14 items have 7 on the left side (the others on the right). The total score is obtained by summing up of all items and then dividing by 30. To score a subscale, sum the items in that scale and divide by the number of items in that scale. The subscale Laxness consists of 11 items, Overreactivity ten items and Verbosity seven items.

In this study, the results show that Cronbach's coefficient alpha for the 30-item scale of the PS in total is α = .889 for the bereaved sample while α = .906 for the non-bereaved sample. Furthermore, Cronbach's coefficient alpha for the three subscales PS-Laxness (α = .72), PS-Overreactivity (α = .74), and PS-Verbosity (α = .70) for bereaved sample, while PS-Laxness (α = .75), PS-Overreactivity (α = .80), and PS-Verbosity (α = .65) for the non-bereaved sample.

The Parenting Scale was used in adolescent version (PSA) to assess parenting styles especially negative parenting reaction to their children and with no limit setting (Irvine, Biglan, Smolkowski, & Ary, 1999). The parents' reaction to their children's behaviour was measured by the overreactivity scale and the laxness scale. Higher score in these scales showed poor parenting styles as in original scale that was developed by Arnold, O'Leary, Wolff, and Acker (1993). Test—retest reliability correlations at 3 months were .79 for Overreactivity, .77 for Laxness, and .80 for the total score (Irvine et al., 1999).

Procedure

I was fully aware of the sensitivity of my topic and therefore I approached the

whole research process with extreme caution. At the beginning of this Study, I first contacted participants for my Study 1. Then for Study 2 four schools were approached and frequently visited in search of parents with bereaved child. Senior university students and colleagues were approached if they were parents of a bereaved child. Luton's top charity the Salvation Army was visited for this purpose. They were fully explained the study and questionnaires were sent to them but none of the parents gave any response as they said their children are toddlers and too young to understand and react to bereavement experiences.

Initially, after getting acquainted with the participants' criteria, the nature and aim of the study was explained verbally than the informed consent form was given and finally, the questionnaires were explained. If they had more than one bereaved child, they were asked to select the one most problematic. They took about 10–15 minutes to complete the questionnaires. Most of them completed and returned them to me at the same time, but some of them took a few weeks to return them. I approached them again and again and even sent them reminders. Along with the questionnaires, a debrief form was provided to the participants with information about me and my supervisor's contact details and the local bereavement service, CHUMS, contact details, so if they became seriously upset after completing the questionnaires, they could contact them.

The data collection process was very slow and full of hurdles, which delayed the process. Firstly, the participants took a long time to agree to participate. Sometimes they left the questionnaires half-complete or took about a week to complete. Secondly, they thought it very personal information and refused to respond. Thirdly, the Salvation Army took a long time and did not respond in the end. Fourthly, sometimes participants lost the questionnaires and had to be provided again. Sometimes they agreed at first but then they returned them without completing them.

Approaching the parents of children without any bereavement experience was easier and without major hurdles. Thus data collection among the non-bereaved group was very quick and smooth. One hundred and one questionnaires were distributed directly to the participants in the local Luton community.

Ethical Issues in the Study

It is the utmost duty of a researcher to promote the respect and autonomy of the participants. I was fully aware that my research involved a very sensitive topic therefore I approached the whole research process, particularly data collection with extreme caution. I applied the BPS ethics code throughout and I attended meetings with my supervisors so that I got training to administer data collection properly.

As in most cases the deceased would be expected to be close to the parent as well, the parents themselves might also be bereaved and therefore be in a potentially vulnerable position. To minimize potential distress in the mother I took the following additional measures:

a. If the deceased was also close to the mother (that is, the mother's partner, parent, sibling, child, or a good friend) I allowed a minimum period of six months after the loss before the mother participated in the research. This was a time period considered in the relevant literature as reasonable so that the bereaved had gone out of the initial shock of the loss (Stroebe, Stroebe, & Schut, 2003). However, if a participant requested more time, the interview of course was postponed or cancelled.
b. I allowed enough time for participants to think carefully whether they were certain they wished to participate in the study – I allowed three days between first participant contact and questionnaire delivery.

c. Prior to the study commencing I asked if they suffered from a serious physical or psychiatric illness, had responded badly to bereavement, or were experiencing any other kind of distress. If they did, they were excluded from the study.
d. I was vigilant throughout the study for any signs of participant distress or hesitation. If I observed such signs or was asked directly by the participant I interrupted questionnaire completion, postponed it, or cancelled it.
e. I provided information about the study in writing and verbally and took a written consent from them. Participants were reassured that information would be anonymous and strictly confidential and all data would be kept safe.
f. Although I was expecting participants not to be under serious distress, mild distress is possible even later after questionnaire completion. To address that I provided them with the contact details of the local bereavement/counselling organizations including child mental health services. Also, they were given my contact details and those of my supervisor for any questions or comments they might have.

In designing and conducting my research I had reflected on the methodological and ethical issues in bereavement research discussed in the relevant literature, for example, by Stroebe, Stroebe, and Schut (2003). Such issues involved the benefits and limitations of using quantitative and qualitative methods in research with those that have been bereaved. Also, I recognized that those who have been bereaved may not admit to themselves or the interviewer feelings of well-being as this goes against social norms of grieving (Stroebe et al., 2003).

Methodological Issues in the Study

The major methodological problem in this study was the validity of parental

accounts. As Kroes, Veerman, and Bruyn (2003, p.196) say, “Despite the problems of sampling and criterion validity, there is growing evidence that parental distress or psychopathology is significantly related to emotional and behavior problems in their children *and* may cause small to moderate parental reporting distortions”. To address this problem I very carefully chose measures which have been found to be valid and reliable with this target group.

Data Analysis and Results

Information about the data analyses and results is presented in Table 5.3, including frequencies and descriptive statistics for all study variables, correlation analyses were used to find the relationship between the subscales of the five questionnaires, and regression analyses used to test the moderation effects of parent attachment styles, parent-complicated-grief and parenting styles.

Table 5.3

Descriptive Statistics for study variables

Variables	Group	N	Mean	SD
SDQ	Bereaved	139	22.73	8.863
	Non-bereaved	101	22.05	8.311
SDQ-Emotional-Problem	Bereaved	139	4.66	2.436
	Non-bereaved	101	4.04	2.490
SDQ-Conduct-Problem	Bereaved	139	3.99	2.122
	Non-bereaved	101	4.04	1.822
SDQ-Hyperactivity	Bereaved	139	4.52	2.339
	Non-bereaved	101	4.83	2.196
SDQ-Peer-Problem	Bereaved	139	4.14	2.344
	Non-bereaved	101	4.65	2.056
SDQ-Prosocial	Bereaved	139	5.42	2.545
	Non-bereaved	101	4.49	2.335
ECR-Avoidance	Bereaved	139	65.38	22.113
	Non-bereaved	101	64.96	17.726
ECR-Anxiety	Bereaved	139	63.41	22.279
	Non-bereaved	101	58.80	22.625
Parent-complicated-grief	Bereaved	139	38.64	19.465
	Non-bereaved	101	29.77	13.161
PS-Laxness	Bereaved	139	38.01	11.715
	Non-bereaved	101	37.18	12.642
PS-Overreactivity	Bereaved	139	37.83	11.591
	Non-bereaved	101	35.64	13.203
PS-Verbosity	Bereaved	139	26.07	9.070
	Non-bereaved	101	25.04	8.973

CSQ-TOTAL	Bereaved	139	42.14	14.768
CSQ-Immediate-Response Score	Bereaved	139	5.95	2.580
CSQ-Reexperiencing	Bereaved	139	8.68	3.407
CSQ-Avoidance	Bereaved	139	6.00	2.499
CSQ-Numbing-and-Dissociation	Bereaved	139	9.55	3.725
CSQ-Increased Arousal	Bereaved	139	7.44	2.896
CSQ-Impairment-in-Function	Bereaved	139	4.53	2.191

Hypothesis 1

To address the hypothesis 1 I ran the MANOVA analysis to explore if there were any significant differences in child problem (DV) and between the bereavement and non-bereavement groups (IV). Both parent attachment dimensions, parenting styles, and parent-complicated-grief were potential confounding variables and controlled for as a "covariate" in the MANOVA. I ran the MANOVA between bereavement vs. non-bereavement status (IV) and child problems subscales (DVs). The results showed significant differences in SDQ-Hyperactivity and SDQ-Peer-Problem scales ($p < .05$) but no significant differences in SDQ-Emotional-Problem, SDQ-Conduct-Problem, and Prosocial scales.

Table 5.4

Differences in study variables between bereaved and non-bereaved groups.

	Non-Bereaved Group		Bereaved Group		df	Mean Square	F	Sig.
Dependent Variables	**Mean**	**SD**	**Mean**	**SD**				
SDQ-Emotional-Problem	4.04	2.490	4.66	2.436	1	.119	.025	.874
SDQ-Conduct-Problem	4.04	1.822	3.99	2.122	1	10.17	3.267	.072
SDQ-Hyperactivity	4.83	2.196	4.52	2.339	1	29.49	7.550	.006
SDQ-Peer-Problem	4.65	2.056	4.14	2.344	1	33.76	9.082	.003
SDQ-Prosocial	4.49	2.335	5.42	2.545	1	8.21	1.664	.198
SDQ-Total	22.05	8.311	22.73	8.863	1	125.90	2.644	.105

Hypothesis 2

To address hypothesis 2 I ran a correlation analysis to see that among the bereaved children, child behavioural problems were expected to have significant correlation with both parent attachment dimensions;,parent-complicated-grief, parenting style, duration of bereavement, and closeness with the deceased.

The results indicated that SDQ-Emotional-Problem showed a significant positive correlation with both parent attachment dimensions, parenting style, and parent-complicated-grief but no correlation with duration of bereavement and closeness to the deceased. SDQ-Conduct-Problem showed significant positive correlation with both parent attachment dimensions, parent-complicated-grief, and parenting style except PS-Laxness, while no correlation to closeness to the

deceased and duration of bereavement. SDQ-Hyperactivity showed significant positive correlation with both parent attachment dimensions, parenting style, parent-complicated-grief, and duration of bereavement but no correlation with closeness to the deceased. SDQ-Peer-Problem showed significant positive correlation to both parent attachment dimensions, parenting style, and parent-complicated-grief but no significant correlation to duration of bereavement and closeness to the deceased. SDQ-Prosocial showed positive significant correlation with both parent attachment dimensions, PS-Verbosity, and parent-complicated-grief while no correlation to PS-Laxness, PS-Overreactivity, duration of bereavement, and closeness to the deceased.

Table 5.5

Correlations between study variables in the bereaved sample

N=139	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**
1. SDQ-Emotional-Problem	1												
2. SDQ-Conduct-Problem	.44**	1											
3. SDQ-Hyperactivity	.54**	.49**	1										
4. SDQ –Peer	.38**	.54**	.57**	1									
5. SDQ-Prosocial	.55**	.33**	.41**	.24**	1								
6. ECR-Avoidance	.28**	.37**	.41**	.47**	.17**	1							
7. ECR-Anxiety	.30**	.31**	.36**	.38**	.24**	.67**	1						
8. PS-Laxness	.20**	.10	.24**	.21**	.09	.35**	.36**	1					

9. PS-Overreactivity	.23**	.27**	.28**	.26**	.08	.50**	.39**	.60**	1				
10. PS-Verbosity	.16**	.20**	.24**	.19**	.16*	.42**	.42**	.69**	.69**	1			
11. Parent Compl Grief	.47**	.41**	.40**	.33**	.44**	.44**	.48**	.15*	.28**	.19**	1		
12.Bereavement Duration	.01	-.06	.18*	.02	.01	.07	-.02	.11	.01	.02	.00	1	
13. Closeness to the Deceased	.00	.01	.00	.03	-.02	-.06	-.07	-.01	.05	.08	.01	.08	1

**: probability below .01 *: probability below.05

Hypothesis 3

To address hypothesis 3 I ran a correlation analysis to see that among bereaved group child reaction to bereavement was expected to significantly correlate with both parent attachment dimensions, parent-complicated-grief, parenting style, duration of bereavement, and closeness with the deceased. The results for CSQ-Immediate-Response showed a positive significant correlation to closeness to the deceased while no correlation to ECR-Avoidance, ECR-Anxiety, PS-Overreactivity, PS-Verbosity, parent-complicated-grief, and duration of bereavement while significant negative correlation to PS-Laxness. CSQ-Reexperiencing showed no significant correlation to any variable except parent-complicated-grief. CSQ-Avoidance showed no significant correlation to any variable but significant negative correlation to duration of bereavement. CSQ-Numbing-and-Dissociation indicated a significant positive correlation to ECR-Anxiety and duration of bereavement while no significant correlation to other variables. CSQ-Increased Arousal showed significant positive correlation only to ECR-Anxiety and no significant correlation to other variables. CSQ-Impairment-in-Function showed no significant correlation to any of the variables.

Table 5.6

Correlations between study variables in the bereaved sample

N=139	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
1. CSQ-Immed Response	1													
2. CSQ-Reexperiencing	.60**	1												
3. CSQ-Avoidance	.53**	.65**	1											
4. CSQ-Numbing-and-Dissociation	.58**	.75**	.67**	1										
5. CSQ-Increas Arousal	.66**	.74**	.68**	.81**	1									
6. CSQ-Impair-in-Function	.57**	.64**	.65**	.68**	.66**	1								
7. ECR-Avoidance	-.02	.06	.06	.07	.12	.06	1							
8. ECR-Anxiety	.09	.14	.09	.19*	.19*	.05	.67**	1						
9. PS-Laxness	-.21*	-.06	.01	-.11	-.14	-	.36**	.32**	1					

						.05								
10. PS-Overreactivity	.03	.07	.14	.06	.07	.13	.51**	.37**	.55**	1				
11. PS-Verbosity	-.12	-.05	.00	-.10	-.08	-.09	.43**	.41**	.68**	.65**	1			
12. Parent Complic Grief	.03	.19*	.09	.15	.15	.06	.48**	.55**	.19*	.31**	.21*	1		
13.Bereavement Duration	-.13	-.13	-.20*	.18*	-.15	-.12	.07	-.02	.11	.01	.02	.00	1	
14. Closeness to Deceased	.16*	.15	.04	.08	.14	.03	-.06	-.07	-.01	.05	.08	.01	.08	1

*Note.***: probability below .01 *:probability below .05

Hypothesis 4

To address hypothesis 4 I ran a Hierarchical multiple linear regression analysis to see that both parent attachment dimensions (anxiety and avoidance) would moderate the link between bereavement status and child problems (SDQ). Bereavement status (group) was put as IV, child problems (SDQ) as DV, while parent-age, parent-gender, ECR-Avoidance, PS-Total, and parent-complicated-grief were controlled for. In the first step, controlled variables were entered, in second step bereavement status and the moderator (ECR-Anxiety and then ECR-Avoidance in the second analysis) were entered and in final step the interaction bereavement-statusXECR-Anxiety (bereavement-statusXECR-Avoidance in the second analysis) was added.

The results showed that both parent attachment dimensions moderated the relationship between bereavement status and behavioural problems in children (see Appendix V Table 1). Specifically, ECR-Anxiety moderated the impact of bereavement status on SDQ-Emotional-Problem, SDQ-Conduct-Problem, SDQ-Hyperactivity, SDQ-Peer-Problem and SDQ-Total. Furthermore, ECR-Avoidance moderated the impact of bereavement status on SDQ-Hyperactivity.

Figures 5.1 to 5.4 illustrate that attachment anxiety moderates the relationship between bereavement status and child problems. These figures were created using ModGraph-1 by Paul E. Jose (2008). The statistical data from multiple regression analysis was put in the ModGraph software to obtain the graphical display. The 'Continuous Data Entry' menu was selected in the first step. The descriptive label such as attachment anxiety as a moderator goes at the topmost label of the chart, the main effect label on the x-axis such as bereavement status, child problems as dependent variable on the y-axis such as conduct problems, hyperactivity, peer problem, and attachment anxiety as the moderator. Further data are taken from the regression coefficient (B), the ean and the standard

deviation of the main effect, the moderator, the interaction, and the constant.

Figure 5.1: Attachment anxiety as a moderator in the relationship between bereavement status and SDQ-Emotional-Problem

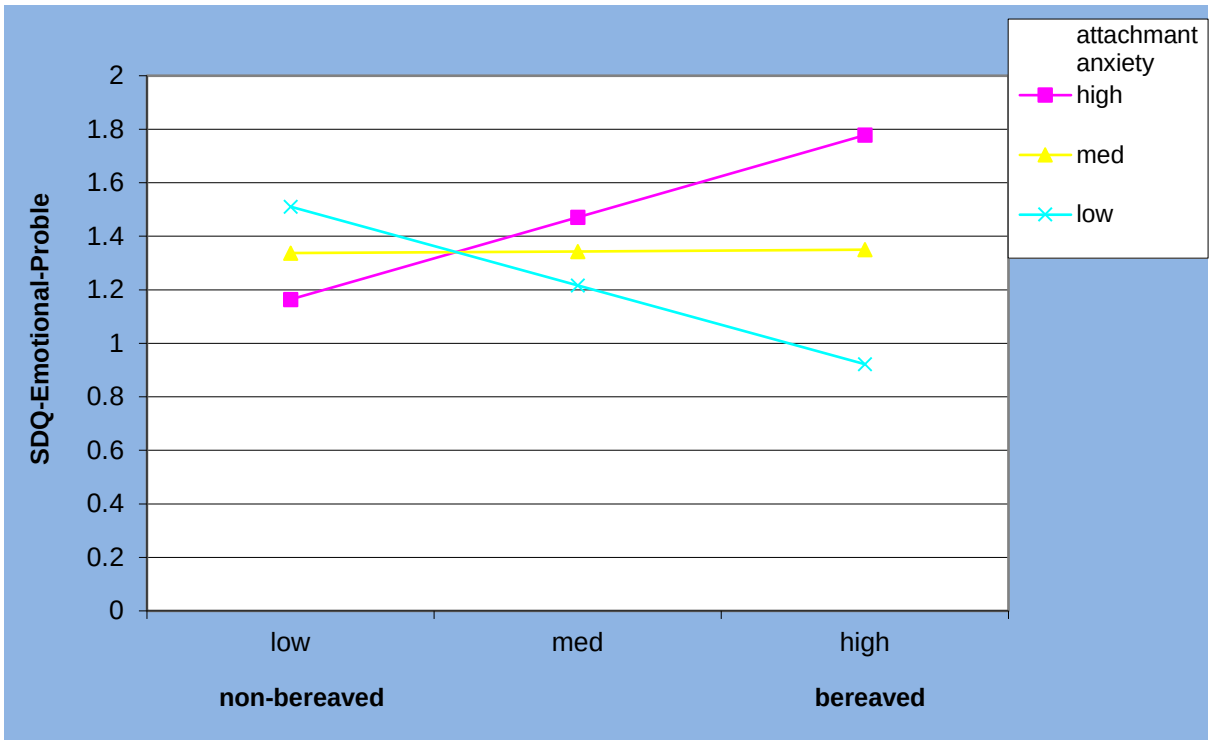


Figure 5.1 demonstrates a moderation effect of attachment anxiety in the relationship between bereavement-status and child emotional problem (SDQ-Emotional-Problem). The ModGraph indicated that bereaved children showed more emotional problems when their parents scored high attachment anxiety while parental anxiety has no effect on child problems in the non-bereaved group.

Figure 5.2: Attachment anxiety as a moderator in the relationship between bereavement-status and SDQ-Conduct-Problem

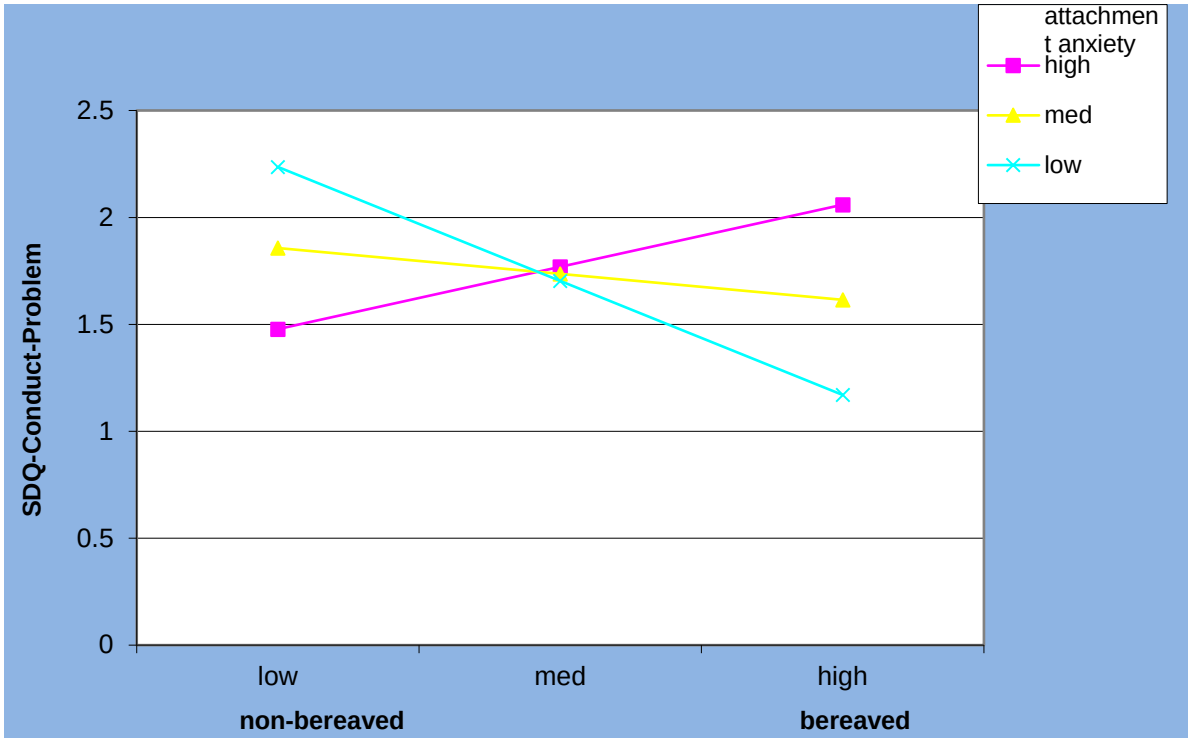


Figure 5.2 demonstrates a moderation effect of attachment anxiety in the relationship between bereavement-status and child conduct problem (SDQ-Conduct-Problem). The ModGraph indicated that bereaved children showed more conduct problems when their parents scored high attachment anxiety while parental anxiety has no effect on child problems in the non-bereaved group.

Figure 5.3: Attachment anxiety as a moderator in the relationship between bereavement-status and SDQ-Hyperactivity

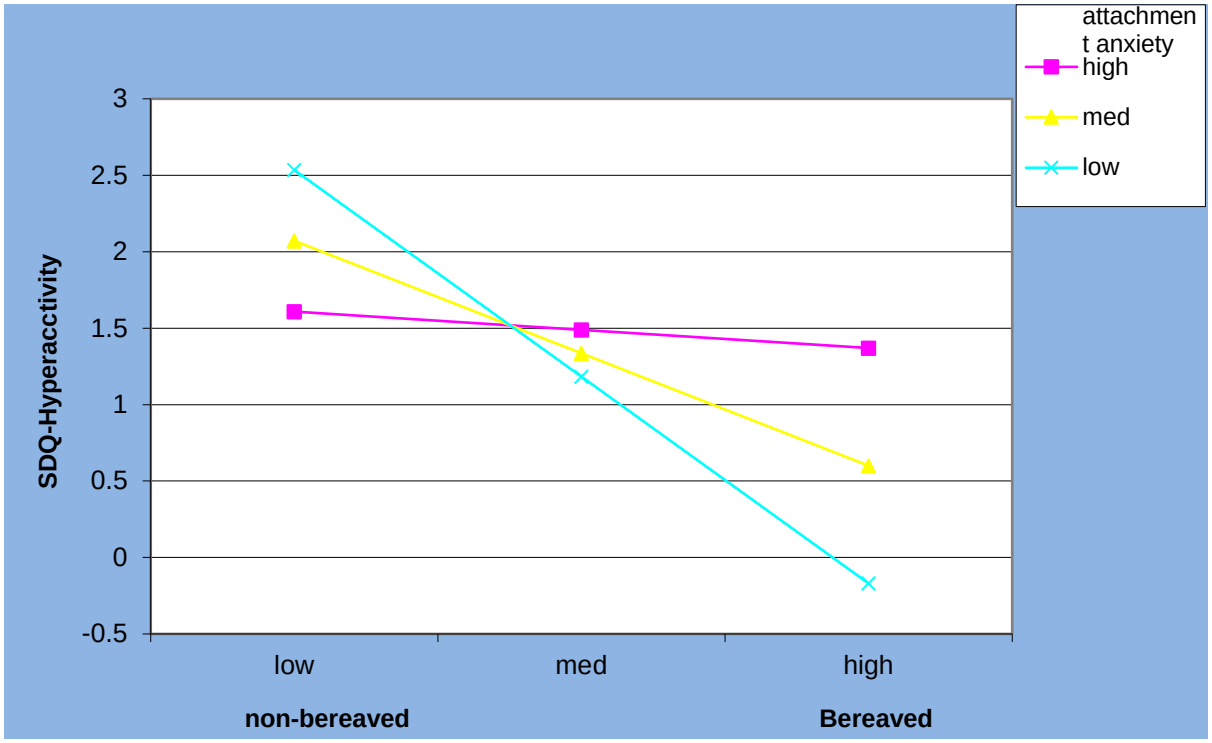


Figure 5.3 demonstrates a moderation effect of attachment anxiety in the relationship between bereavement-status and child hyperactivity (SDQ-Hyperactivity). The ModGraph indicated that bereaved children showed high hyperactivity when their parents scored high attachment anxiety while non-bereaved showed no significant difference in hyperactivity when their parents indicated high attachment anxiety.

Figure 5.4: Attachment anxiety as a moderator in the relationship between bereavement-status and SDQ-Peer-Problem

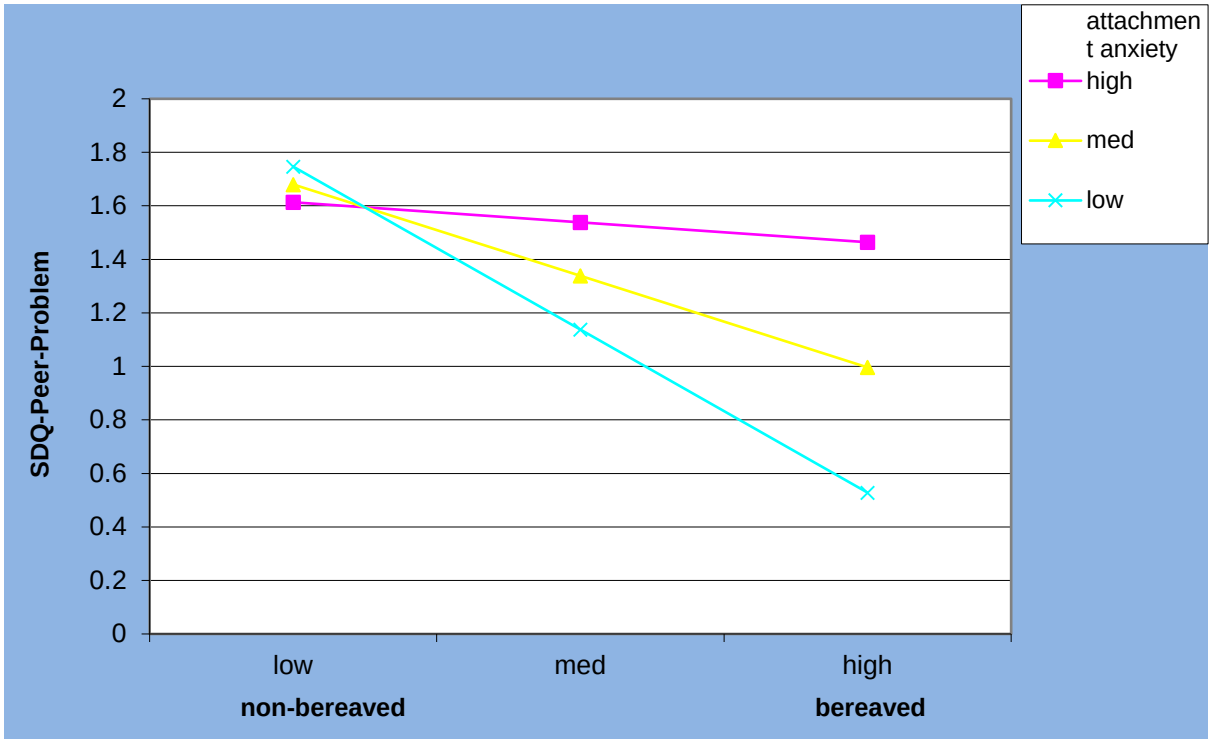


Figure 5.4 demonstrates a moderation effect of attachment anxiety in the relationship between bereavement-status and child peer problem (SDQ-Peer-Problem). The ModGraph indicated that bereaved children showed more peer problems when their parents scored high in attachment anxiety.

Figure5.5: Attachment avoidance as a moderator in the relationship between bereavement-status and SQQ-Hyperactivity

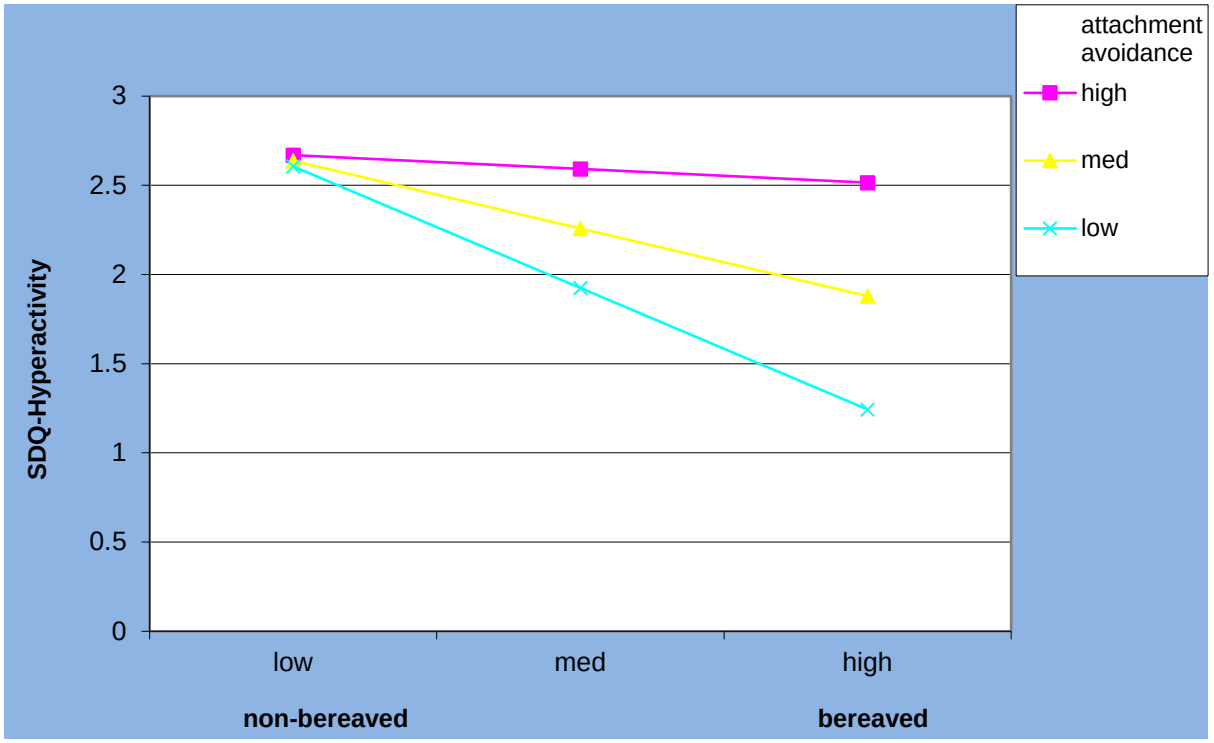


Figure 5.5 demonstrates a moderation effect of attachment avoidance in the relationship between bereavement-status and child hyperactivity (SDQ-Hyperactivity). The ModGraph indicated that bereaved children showed more hyperactivity when their parents scored high in attachment avoidance.

Hypothesis 5

To address hypothesis 5 I ran a Hierarchical multiple linear regression analysis to see that parent-complicated-grief would moderate the link between bereavement- status and child-problems (SDQ). Bereavement-status (Group) was put as IV, child-problems (SDQ) as DV, while parent-age, parent-gender, ECR-Anxiety, ECR-Avoidance, and PS-Total were controlled for. In the first step controlled variables were entered, in the second step bereavement-status and the moderator (parent-complicated-grief) were entered and in final step the interaction bereavement-statusXparent-complicated-grief was added. The results

showed that parent-complicated-grief did not moderate the relation between bereavement status and child problems (see Appendix V Table 3).

Hypothesis 6

To address hypothesis 6 I ran a Hierarchical multiple linear regression analysis to see parenting styles (PS-Laxness, PS-Verbosity, and PS-Overreactivity) would moderate the link between bereavement-status and child-problems (SDQ). Bereavement status (group) was the IV, child-problems (SDQ) the DV, while parent-age, parent-gender, ECR-Avoidance, ECR-Anxiety, and parent-complicated-grief were controlled for (see Appendix V Tables 4–7). In the first step controlled variables were entered, in the second step bereavement-status and the moderator, PS-Laxness (then PS-Overreactivity and PS-Verbosity in the second and third analyses) were entered and in the final step the interaction bereavement-statusXPS-Laxness (bereavement-statusXPS-Overreactivity and bereavement-statusXPS-Verbosity in the second and third analyses) was added. The results showed that PS-Laxness and PS-Verbosity did not moderate the relation between bereavement-status and child-problems, only PS-Overreactivity moderated the relation between bereavement-status and SDQ-Prosocial.

The results showed that PS-Overreactivity did not moderate the relation between bereavement-status and child-problems. Only PS-Overreactivity moderated the relation between bereavement-status and SDQ-Prosocial. They also showed that PS-Verbosity indicated no moderation between bereavement-status and all SDQ-Problems and that PS-Total did not moderate the relation between bereavement-status and child-problems (See Appendix V Table 5.13).

Figure 5.6: Parenting overreactivity as a moderator in the relationship between bereavement-status and SDQ-Prosocial

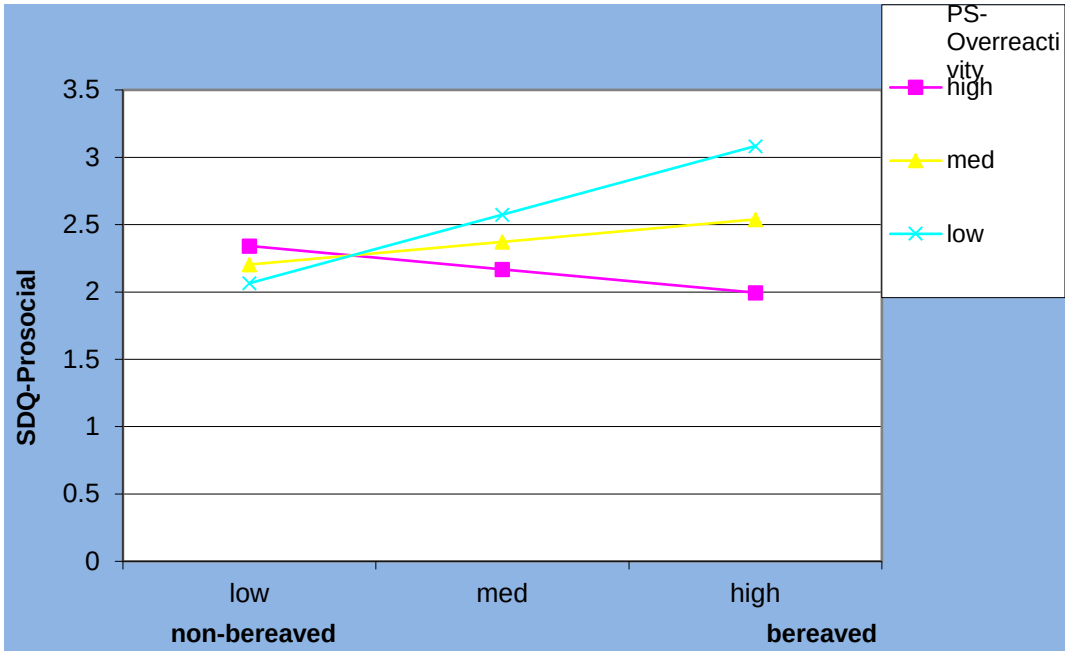


Figure 5.6 shows a moderation effect of parenting overreactivity in the relationship between bereavement-status and child prosocial behaviour (SDQ-Prosocial). Bereavement-status was the independent variable (IV), while SDQ-Prosocial was the dependent variable (DV). The ModGraph indicated that bereaved children showed less prosocial behaviour when their parent scored high in parenting overreactivity.

Hypothesis 7

To address this hypothesis I ran a Hierarchal regression analysis having all child problem scales as DVs and then having the two attachment styles, parent-complicated-grief, and parenting styles as IV (after controlling for age and gender in Step 1). The hypothesis was tested in the two samples separately. In the bereaved sample the results showed that ECR-Avoidance, ECR-Anxiety and parent-complicated-grief were the best predictors of SDQ-Total (see Appendix V Table 8). ECR-Anxiety and parent-complicated-grief were best predictors of SDQ-

Emotional-Problem and SDQ-Conduct-Problem. ECR-Avoidance, ECR-Anxiety, and parent-complicated-grief were best predictors of SDQ-Hyperactivity. ECR-Avoidance and PS-Verbosity were best predictors of SDQ-Peer-Problem while marginally significant to ECR-Anxiety. Parent-complicated-grief, PS-Overreactivity, and PS-Verbosity were good predictors of SDQ-Prosocial.

The results also showed that ECR-Anxiety and PS-Overreactivity were the best predictors of CSQ-Total (see Appendix V Table 9). ECR-Anxiety, PS-Laxness, and PS-Overreactivity were the best predictors of CSQ-Immediate-Response. PS-Overreactivity predicted CSQ-Avoidance. ECR-Anxiety was a best predictor of CSQ-Numbing-and-Dissociation while PS-Overreactivity and PS-Verbosity were marginally significant. ECR-Anxiety, PS-Laxness, and PS-Overreactivity were good predictors of CSQ-Increased-Arousal. PS-Overreactivity and PS-Verbosity were the best predictors of CSQ-Impairment-in-Function.

Hypothesis 7 was also tested in the non-bereaved sample. I ran a Hierarchal regression analysis having all child problem scales as DVs and then having the two attachment styles, parent-complicated-grief, and parenting styles as IV (after controlling for age and gender in Step 1). The results showed that ECR-Anxiety, parent-complicated-grief, and PS-Laxness were the best predictors of SDQ-Total (see Appendix V Table 10). Parent-complicated-grief was the best predictor of SDQ-Total, SDQ-Emotional-Problem, SDQ-Hyperactivity, and SDQ-Prosocial Scale. ECR-Anxiety was the best predictor of SDQ-Conduct-Problem. PS-Laxness was the best predictor of SDQ-Emotional-Problem and SDQ-Hyperactivity.

Hypothesis 8

Firstly, to address hypothesis 8 I ran a Hierarchical multiple linear regression to see that among the bereaved group both parent attachment dimensions (anxiety and avoidance) would moderate the link between parent-complicated-grief and child-problems (SDQ and CSQ). Parent-complicated-grief was put as IV, child-

problems (SDQ and CSQ) as DV, while parent-age, parent-gender, ECR-Avoidance, and PS-Total were controlled for. In the first step controlled variables were entered, in the second step parent-complicated-grief and the moderator (ECR-Anxiety and then ECR-Avoidance in the second analysis) were entered and in the final step the interaction parent-complicated-griefXECR-Anxiety (parent-complicated-griefXECR-Avoidance in the second analysis) was added.

The results showed that both parent attachment dimensions moderated the relationship between parent-complicated-grief and behavioural problems in children (see Appendix V Tables 11–12). Specifically, ECR-Anxiety moderated the impact of parent-complicated-grief on SDQ-Emotional-Problem, CSQ-Immediate-Response, CSQ-Reexperiencing, CSQ-Avoidance, CSQ-Numbing-and-Dissociation, and CSQ-Increased-Arousal while marginally non-significant to CSQ-Impairment-in-Function. ECR-Avoidance moderated the impact of parent-complicated-grief on SDQ-Emotional-Problem, CSQ-Immediate-Response, CSQ-Numbing-and-Dissociation, and CSQ-Increased-Arousal.

Figure 5.7: Parent attachment anxiety as a moderator in the relationship between parent-complicated-grief and SDQ-Emotional-Problem

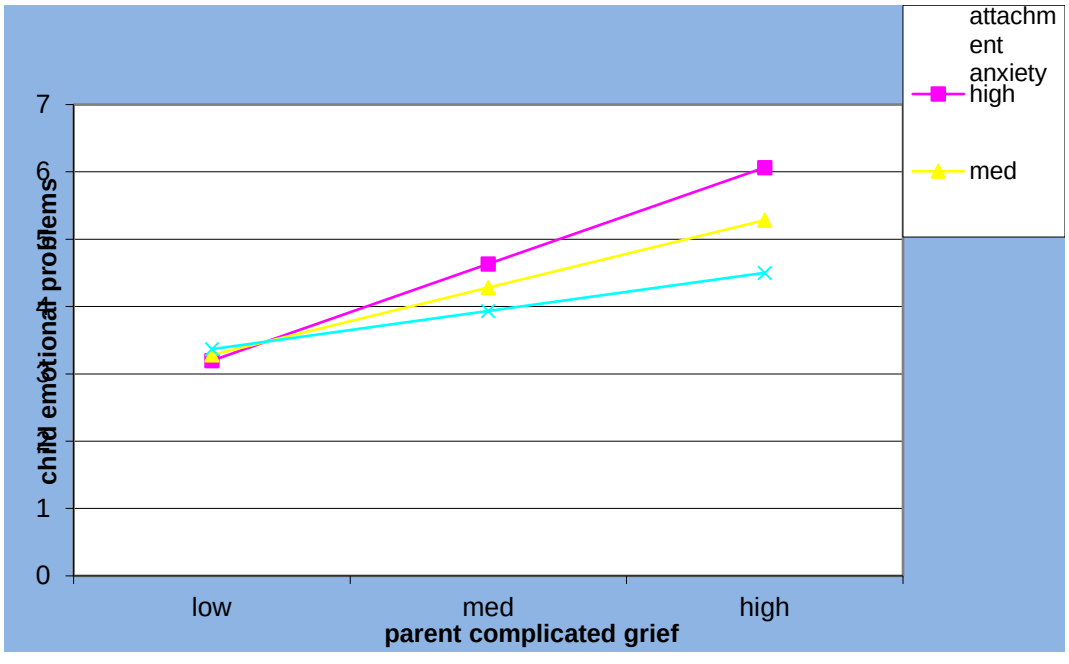


Figure 5.7 shows a moderation effect of parent attachment anxiety in the relationship between parent grief and child emotional problem (SDQ-Emotional-Problem). Parent-complicated-grief was the independent variable (IV), while SDQ-Emotional-Problem was the dependent variable (DV). The ModGraph indicated that children whose parents had higher attachment anxiety presented more emotional problems when those parents also scored higher in complicated grief, while differences in parental attachment anxiety had no effect on child emotional problems when parents had low complicated grief.

Figure 5.8: Parent attachment anxiety as a moderator in the relationship between parent-complicated-grief and CSQ-Immediate-Response

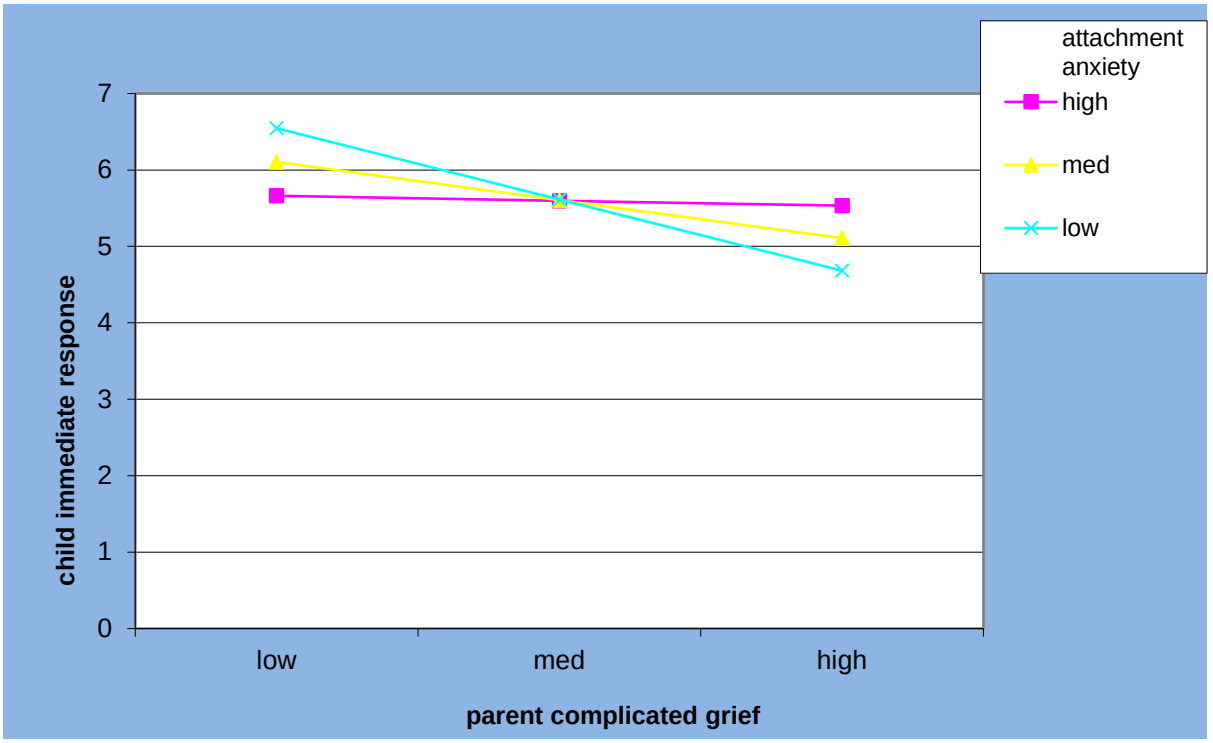


Figure 5.8 shows a moderation effect of parent attachment anxiety in the relationship between parent-complicated-grief and child immediate response (CSQ-Immediate-Response). Parent-complicated-grief was the independent variable (IV), while CSQ-Immediate-Response was the dependent variable (DV).

The ModGraph indicated that children whose parents had high attachment anxiety presented higher immediate response when those parents also scored high in complicated grief, while differences in parental attachment anxiety did not have an effect on child immediate response when parents had low complicated grief.

Figure 5.9: Parent attachment anxiety as a moderator in the relationship between parent-complicated-grief and CSQ-Reexperiencing

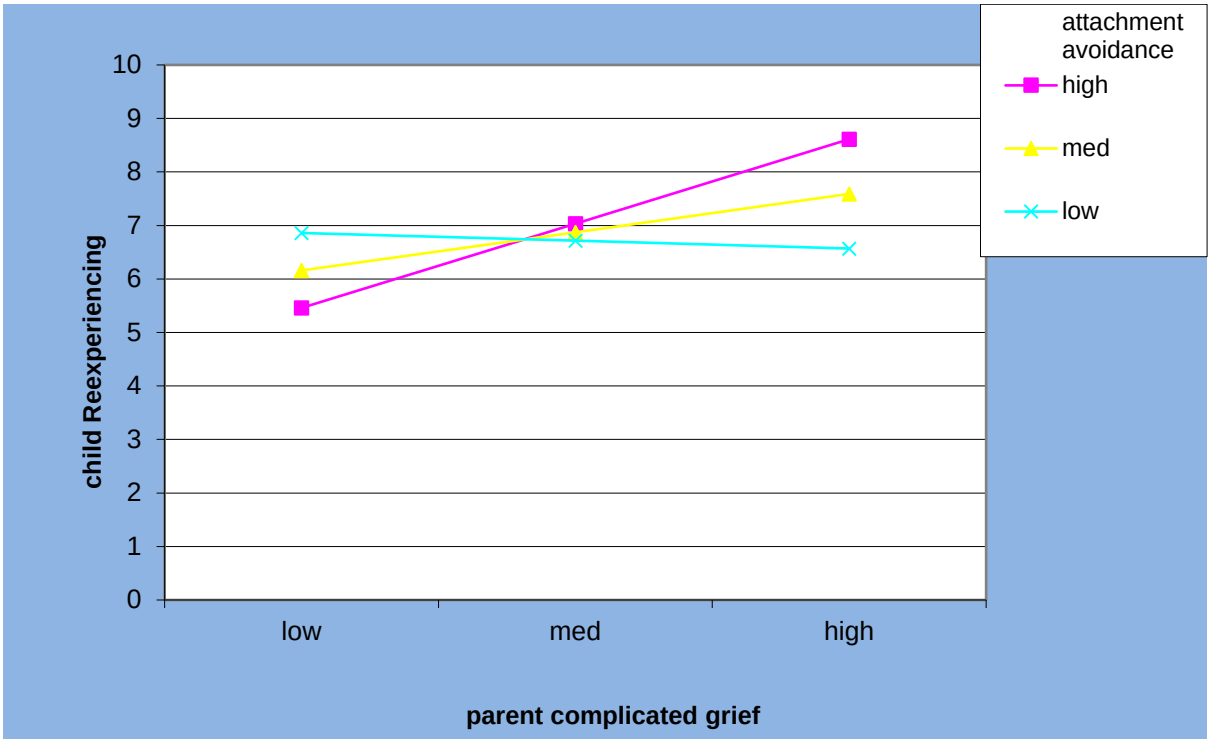


Figure 5.9 shows moderation effect of parent attachment anxiety in the relationship between parent-complicated-grief and child reexperiencing (CSQ-Reexperiencing). Parent-complicated-grief was the independent variable (IV), while CSQ-Reexperiencing was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment anxiety presented higher reexperiencing when those parents also scored high in complicated grief,

while differences in parental attachment anxiety did not have an effect on child reexperiencing when parents had low complicated grief.

Figure 5.10: Parent attachment anxiety as a moderator in the relationship between parent-complicated-grief and CSQ-Avoidance

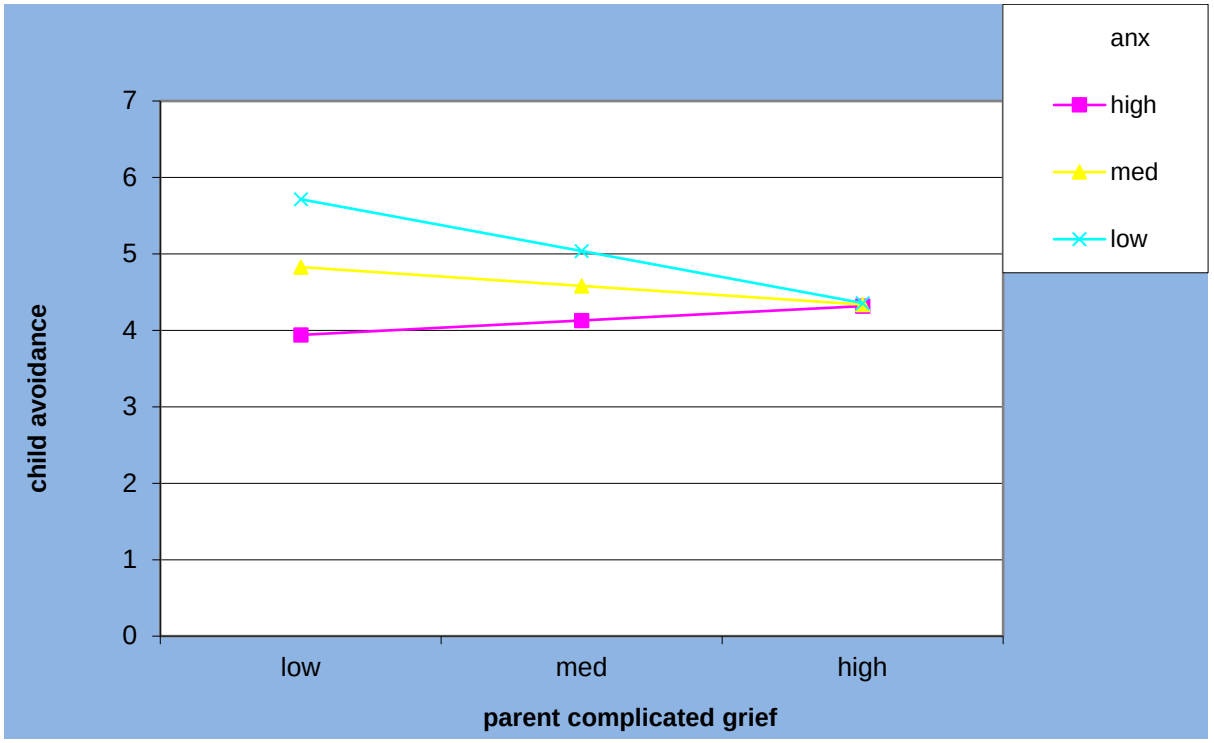


Figure 5.10 shows a moderation effect of parent attachment anxiety in the relationship between parent-complicated-grief and child avoidance (CSQ-Avoidance). Parent-complicated-grief was the independent variable (IV), while CSQ-Avoidance was the dependent variable (DV). The ModGraph indicated that children whose parents had low attachment anxiety presented higher avoidance when those parents also scored low in complicated grief, while differences in parental attachment anxiety had no different effect on child avoidance when parents had high complicated grief.

Figure 5.11: Parent attachment anxiety as a moderator in the relationship between parent-complicated-grief and CSQ-Numbing-and-Dissociation

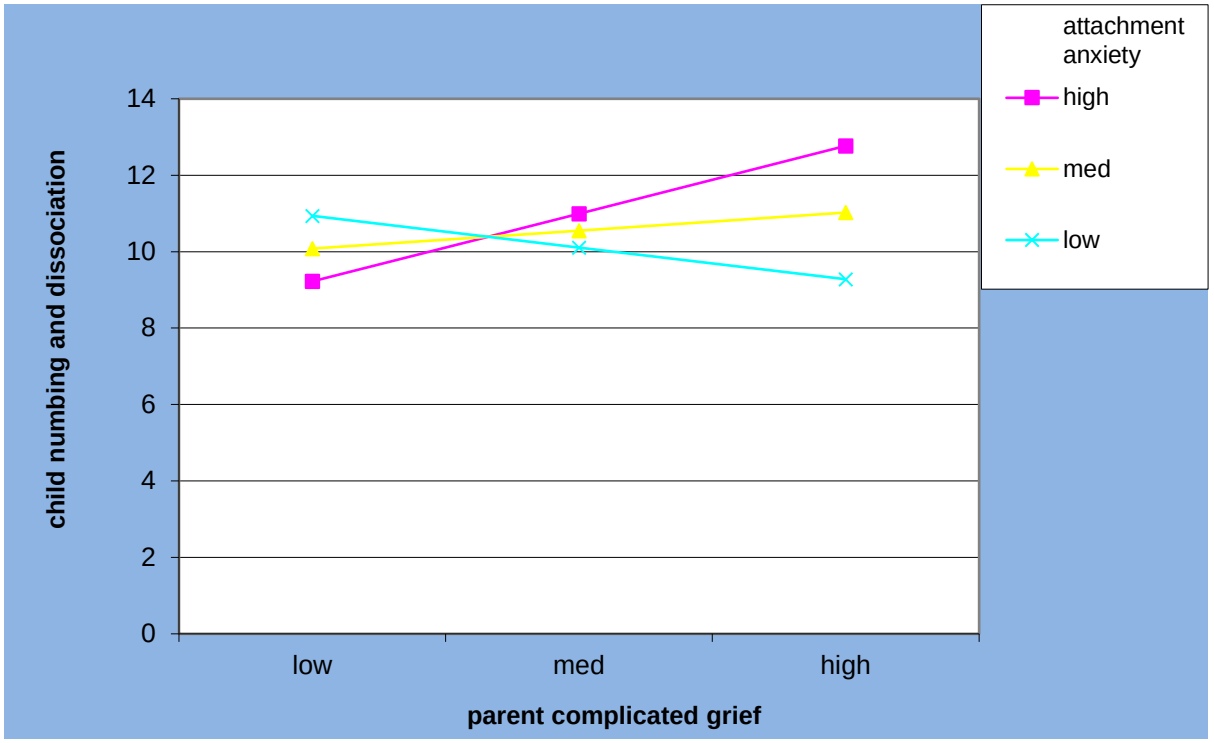


Figure 5.11 shows moderation effect of parent attachment anxiety in the relationship between parent-complicated-grief and child numbing and dissociation (CSQ-Numbing-and-Dissociation). Parent-complicated-grief was the independent variable (IV), while CSQ-Numbing-and-Dissociation was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment anxiety presented higher numbing and dissociation when those parents also scored high in complicated grief, while differences in parental attachment anxiety did not have an effect on child numbing and dissociation when parents had low complicated grief.

Figure 5.12: Parent attachment anxiety as a moderator in the relationship between parent-complicated-grief and CSQ-Increased-Arousal

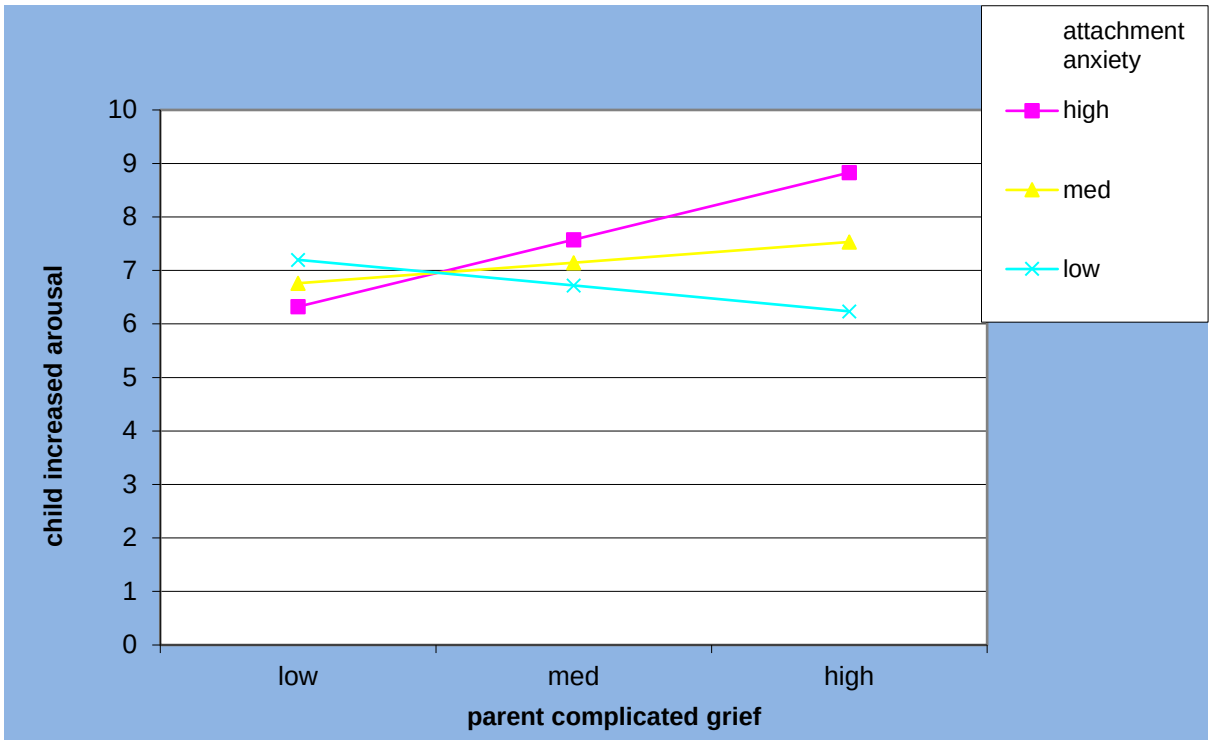


Figure 5.12 shows a moderation effect of parent attachment anxiety in the relationship between parent-complicated-grief and child increased arousal (CSQ-Increased-Arousal). Parent-complicated-grief was the independent variable (IV), while CSQ-Increased-Arousal was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment anxiety presented higher increased arousal when those parents also scored high in complicated grief, while differences in parental attachment anxiety had no effect on child increased arousal when parents had low complicated grief.

Figure 5.13: Parent attachment avoidance as a moderator in the relationship between parent-complicated-grief and SDQ-Emotional-Problems

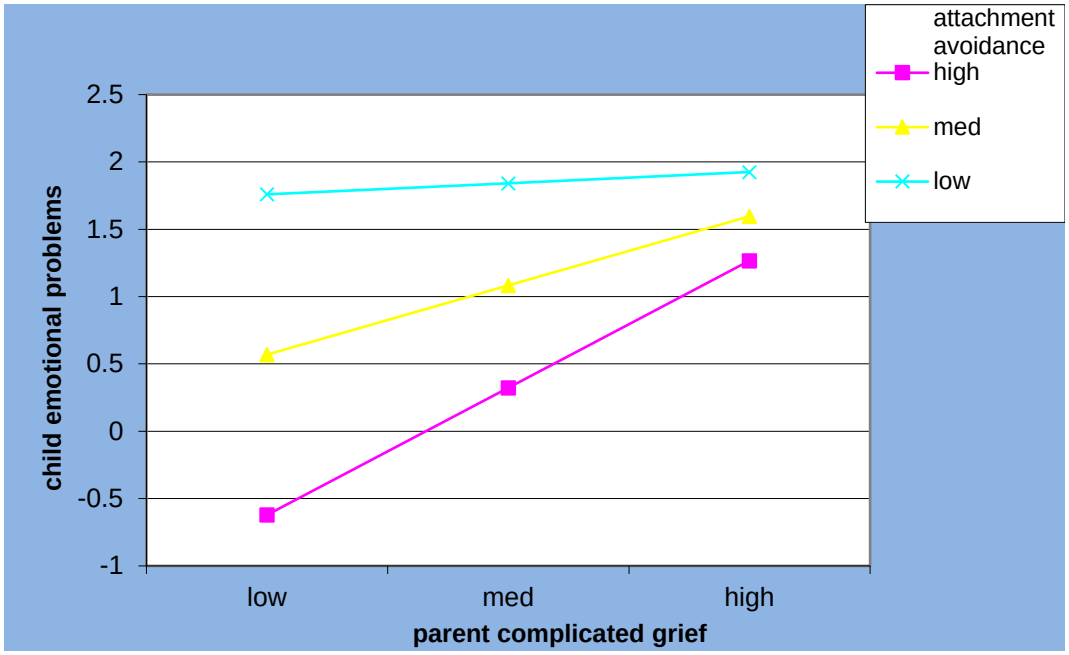


Figure 5.13 shows a moderation effect of parent attachment avoidance in the relationship between parent-complicated-grief and child emotional problem (SDQ-Emotional-Problem). Parent-complicated-grief was the independent variable (IV), while SDQ-Emotional-Problem was the dependent variable (DV). The ModGraph indicated that children whose parents had low attachment avoidance presented more emotional problems when those parents also scored low in complicated grief, while differences in parental attachment avoidance did not have an effect on child emotional problems when parents had high complicated grief.

Figure 5.14: Parent attachment avoidance as a moderator in the relationship between parent-complicated griefand child immediate response

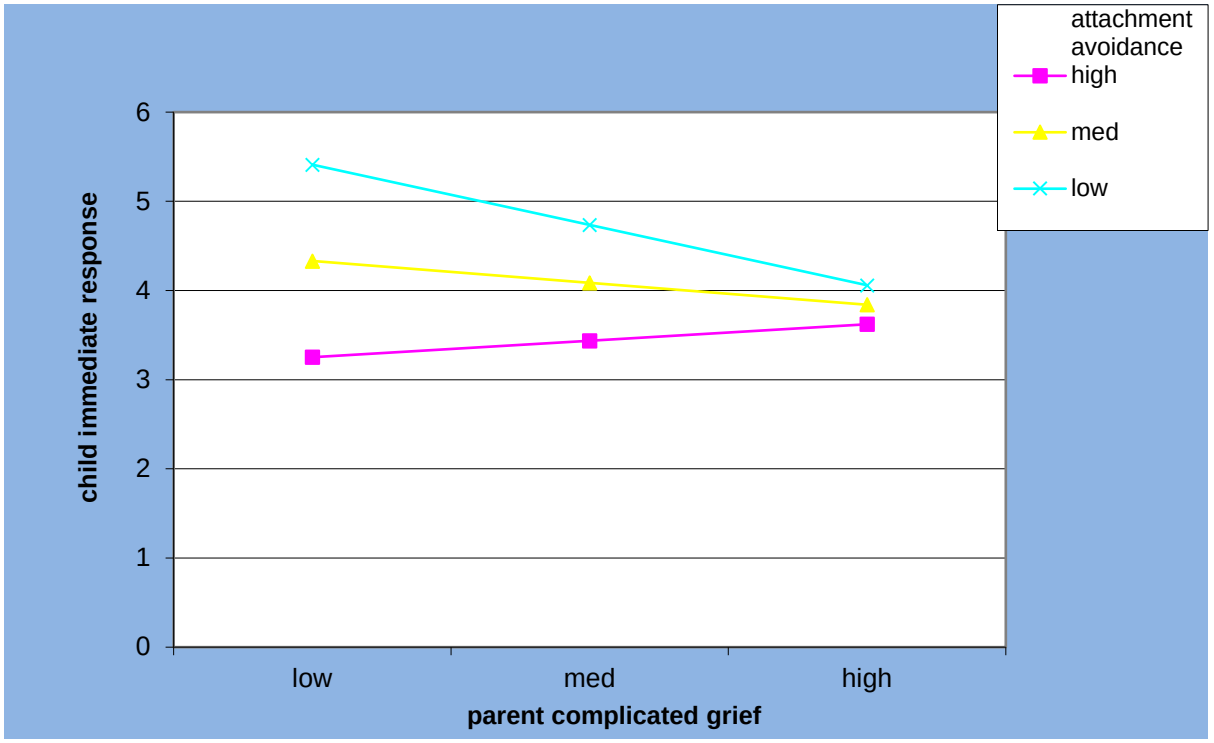


Figure 5.14 shows a moderation effect of parent attachment avoidance in the relationship between parent-complicated-grief and child immediate response (CSQ-Immediate-Response). Parent-complicated-grief was the independent variable (IV), while CSQ-Immediate-Response was the dependent variable (DV). The ModGraph indicated that children whose parents had low attachment avoidance presented higher immediate response when those parents also scored low in complicated grief, while differences in parental attachment avoidance did not have an effect on child emotional problems when parents had higher complicated grief.

Figure 5.15: Parent attachment avoidance as a moderator in the relationship between parent-complicated-grief and CSQ-Numbing-and-Dissociation

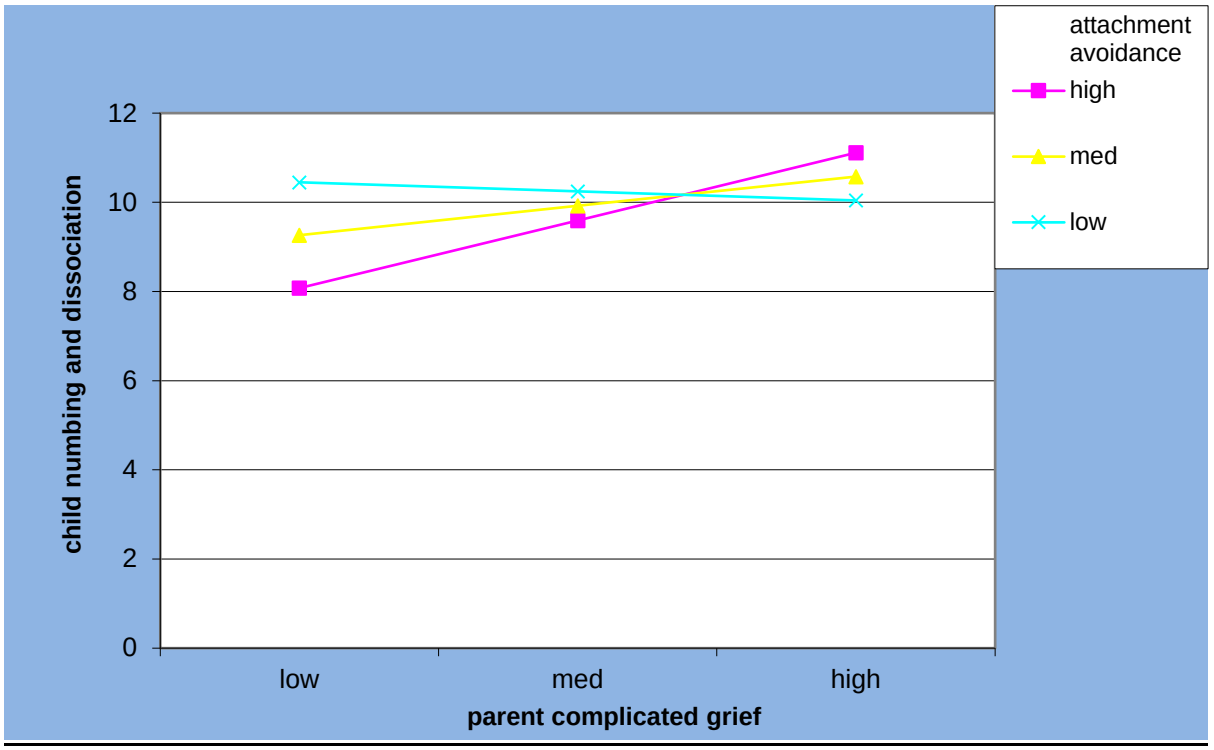


Figure 5.15 shows moderation effect of parent attachment avoidance in the relationship between parent-complicated-grief and child numbing and dissociation (CSQ-Numbing-and-Dissociation). Parent-complicated-grief was the independent variable (IV), while CSQ-Numbing-and-Dissociation was the dependent variable (DV). The ModGraph indicated that children whose parents had lower attachment avoidance presented higher numbing and dissociation when those parents also scored low in complicated grief, while differences in parental attachment avoidance had no effect on child numbing and dissociation when parents had high complicated grief.

Figure 5.16: Parent attachment avoidance as a moderator in the relationship between parent-complicated-grief and CSQ-Increased-Arousal

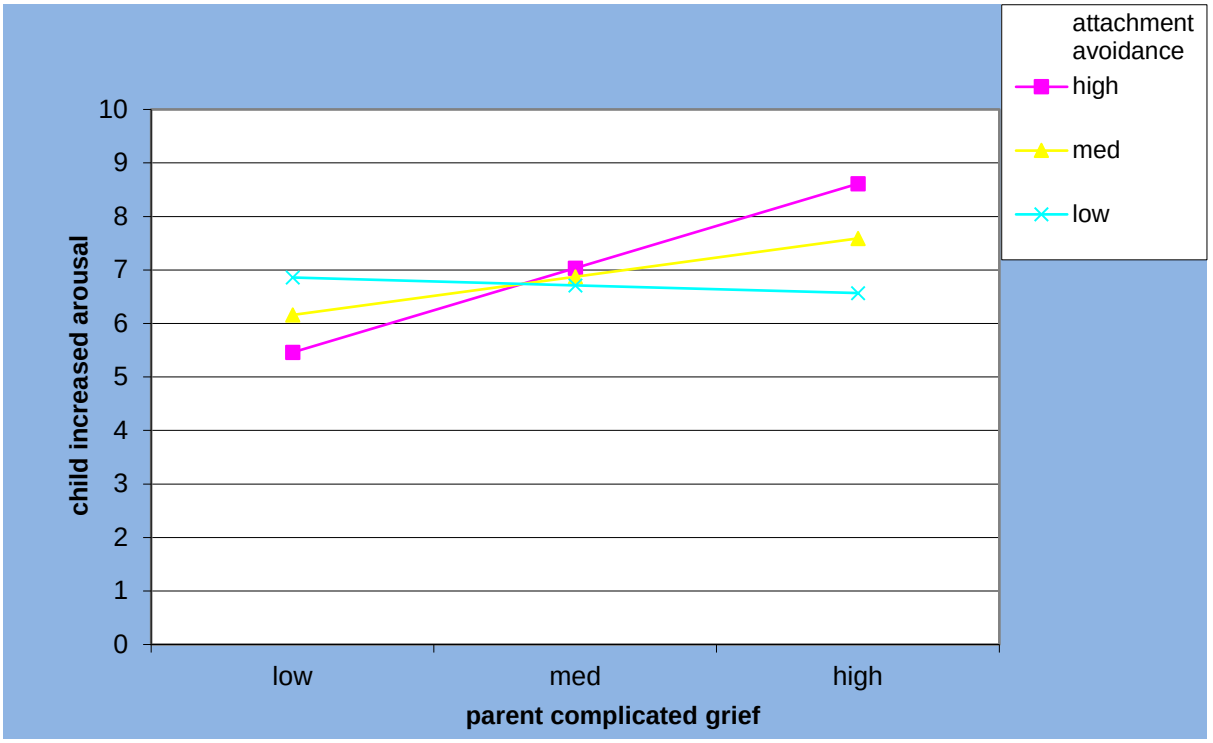


Figure 5.16 shows a moderation effect of parent attachment avoidance in the relationship between parent-complicated-grief and child increased arousal (CSQ-Increased-Arousal). Parent-complicated-grief was the independent variable (IV), while CSQ-Increased-Arousal) was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment avoidance presented higher increased arousal when those parents also scored high in complicated grief, while differences in parental attachment avoidance did not have an effect on child increased arousal when parents had low complicated grief. Finally, I addressed hypothesis 8 in the non-bereaved group only. The results showed that neither parental attachment dimension moderated the relationship between parent-complicated-grief and behavioural problems in children (as measured by the SDQ).

Hypothesis 9

Firstly, to address hypothesis 9 I ran a Hierarchical multiple linear regression analysis to see that both parent attachment dimensions (anxiety and avoidance) would moderate the link between parenting styles and child-problems (SDQ and CSQ) in the bereaved sample. Parenting style was put as IV, child-problems (SDQ and CSQ) as DV, while parent-age, parent-gender, ECR-Avoidance (ECR-Anxiety in the second analysis), and parent-complicated-grief were controlled for. In the first step controlled variables were entered, in the second step parenting styles (PS-Laxness, PS-Overreactivity, and PS-Verbosity in three analyses, respectively) and the moderator (ECR-Anxiety and then ECR-Avoidance in the second analysis) were entered and in the final step the interaction PS-LaxnessXECR-Anxiety (PS-OverreactivityXECR-Anxiety and PS-VerbosityXECR-Anxiety and then PS-LaxnessXECR-Avoidance, PS-OverreactivityXECR-Avoidance, and PS-VerbosityXECR-Avoidance in the second analysis) was added.

The results showed that parent attachment style moderated the relationship between parenting style and behavioural problems in the beareaved children (see Appendix V Tables 13–18). Specifically, ECR-Anxiety moderated the impact of PS-Laxness on SDQ-Emotional-Problems, SDQ-Prosocial, and CSQ-Numbing-and-Dissociation while marginally significant impact on SDQ-Peer-Problem and CSQ-Avoidance. Furthermore, ECR-Anxiety moderated the impact of PS-Overreactivity on SDQ-Prosocial and CSQ-Impairment-in-Function while marginally significant to CSQ-Numbing-and-Dissociation. Finally, it showed moderation of PS-Verbosity on SDQ-Emotional-Problems, SDQ-Prosocial, CSQ-Avoidance, and CSQ-Numbing-and-Dissociation while marginally significant on CSQ-Reexperiencing and CSQ-Impairment-in-Function. Additionally, ECR-Avoidance moderated the impact of PS-Laxness on SDQ-Prosocial, CSQ-Reexperiencing, CSQ-Avoidance, CSQ-Numbing-and-Dissociation, CSQ-Increase-Arousal, and CSQ-Impairment-in-Function. ECR-Avoidance moderated the link

between PS-Overreactivity and SDQ-Prosocial while PS-Verbosity and SDQ-Prosocial, CSQ-Reexperiencing, CSQ-Avoidance, CSQ-Numbing-and-Dissociation, CSQ-Increase-Arousal, and CSQ-Impairment-in-Function and marginally significant to CSQ-Immediate-Response.

Figure 5.17: Parent attachment anxiety as a moderator in the relationship between parent laxness and SDQ-Emotional-Problem

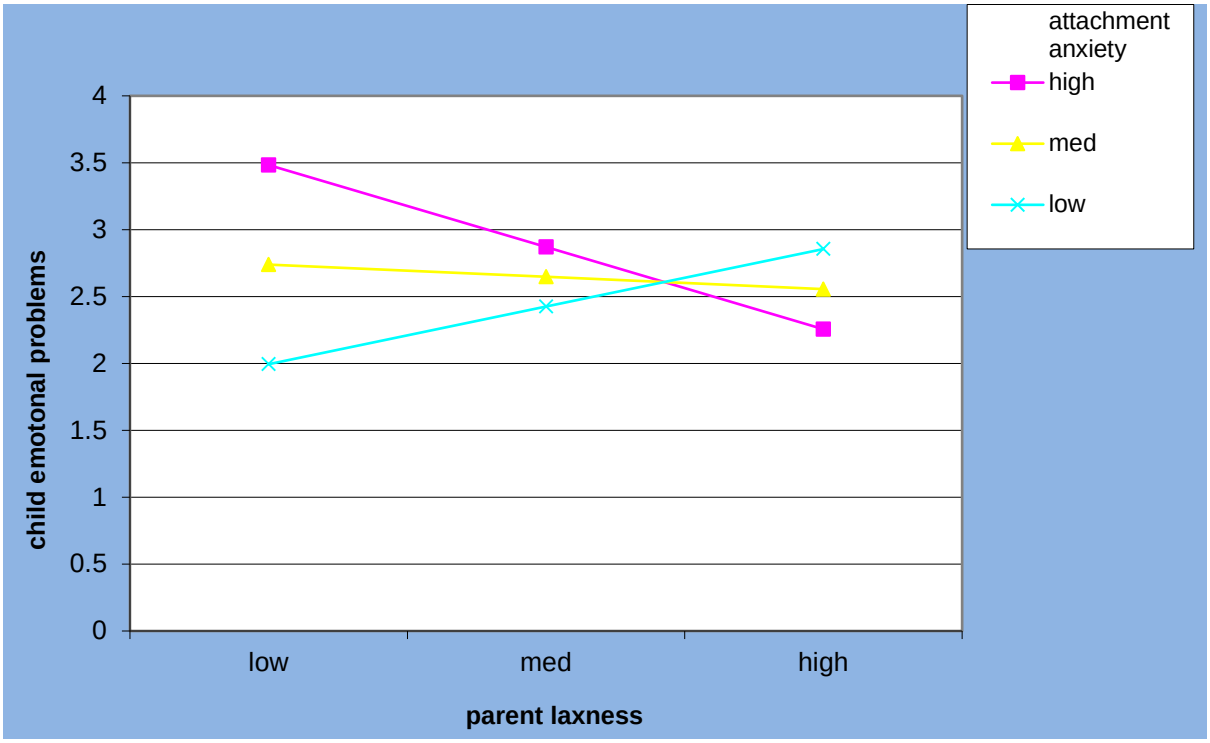


Figure 5.17 shows a moderation effect of parent attachment anxiety in the relationship between parent laxness and child emotional problem (SDQ-Emotional-Problem). Parent laxness was the independent variable (IV), while SDQ-Emotional-Problem was the dependent variable (DV). The ModGraph indicated that children whose parents had low attachment anxiety presented more emotional problems when those parents also scored high in laxness, while differences in parental attachment anxiety had no effect on child emotional problems when parents had high laxness.

Figure 5.18: Parent attachment anxiety as a moderator in the relationship between parent laxnessand SDQ-Prosocial

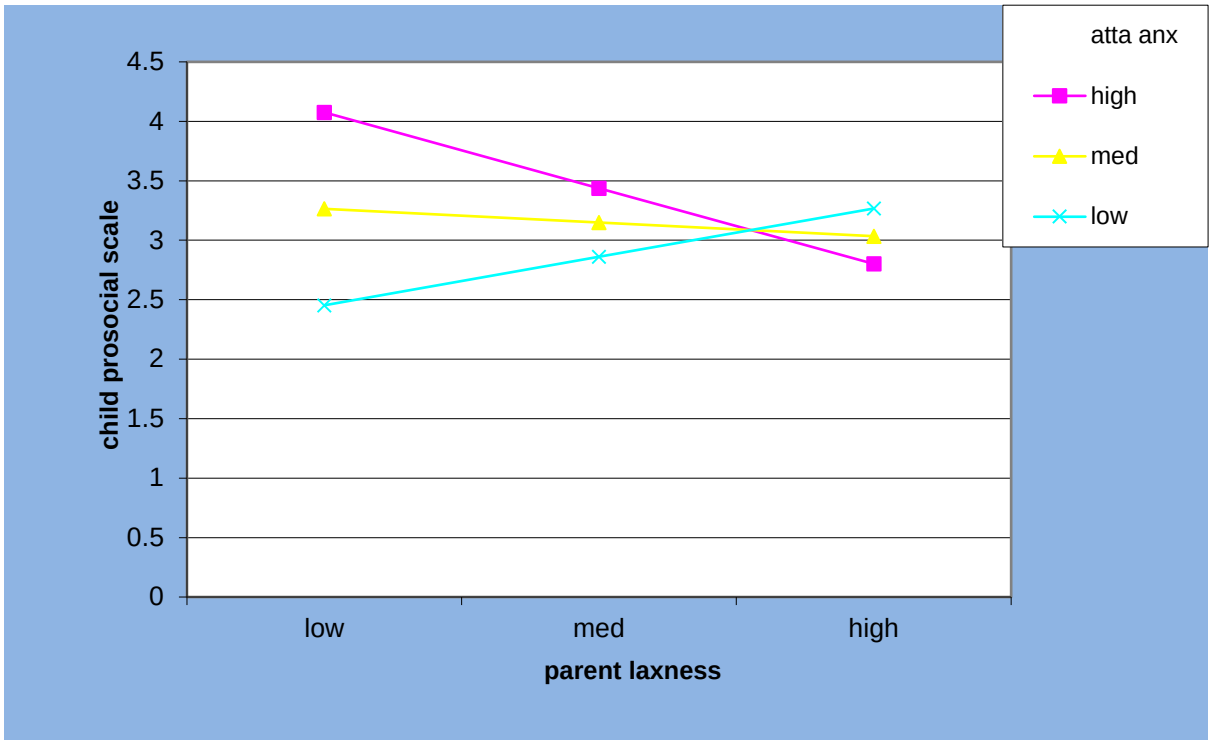


Figure 5.18 shows a moderation effect of parent attachment anxiety in the relationship between parent laxness and child prosocial problem (SDQ-Prosocial). Parent laxness was the independent variable (IV), while SDQ-Prosocial was the dependent variable (DV). The ModGraph indicated that children whose parents had low attachment anxiety presented more prosocial behaviour when those parents also scored low in laxness, while differences parental attachment anxiety had no effect on child avoidance when parents had high attachment anxiety.

Figure 5.19: Parent attachment anxiety as a moderator in the relationship between parent laxness and CSQ-Numbing-and-Dissociation

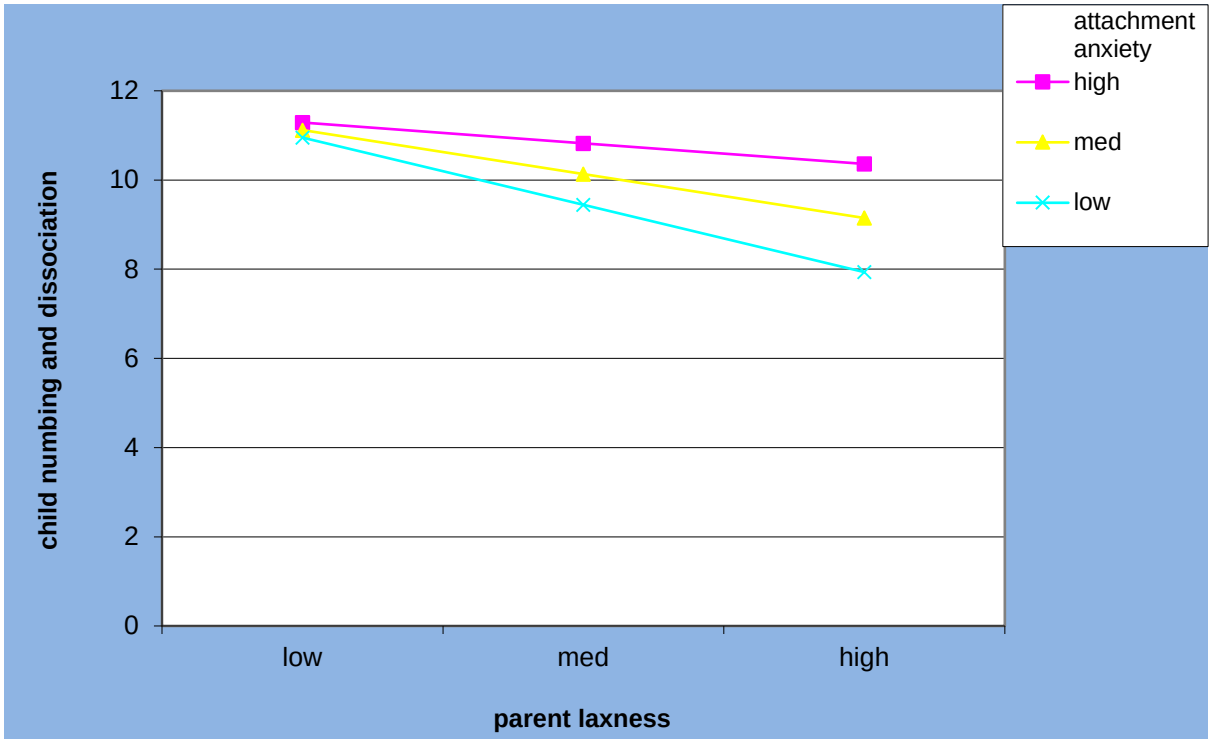


Figure 5.19 shows a moderation effect of parent attachment anxiety in the relationship between parent laxness and child numbing and dissociation (CSQ-Numbing-and-Dissociation). Parent laxness was the independent variable (IV), while CSQ-Numbing-and-Dissociation was the dependent variable (DV The ModGraph indicated that children whose parents had higher attachment anxiety presented more emotional problems when those parents also scored high in laxness, while differences in parental attachment anxiety had no effect on child emotional problem when parents had low laxness.

Figure 5.20: Parent attachment avoidance as a moderator in the relationship between parent laxness and SDQ-Prosocial

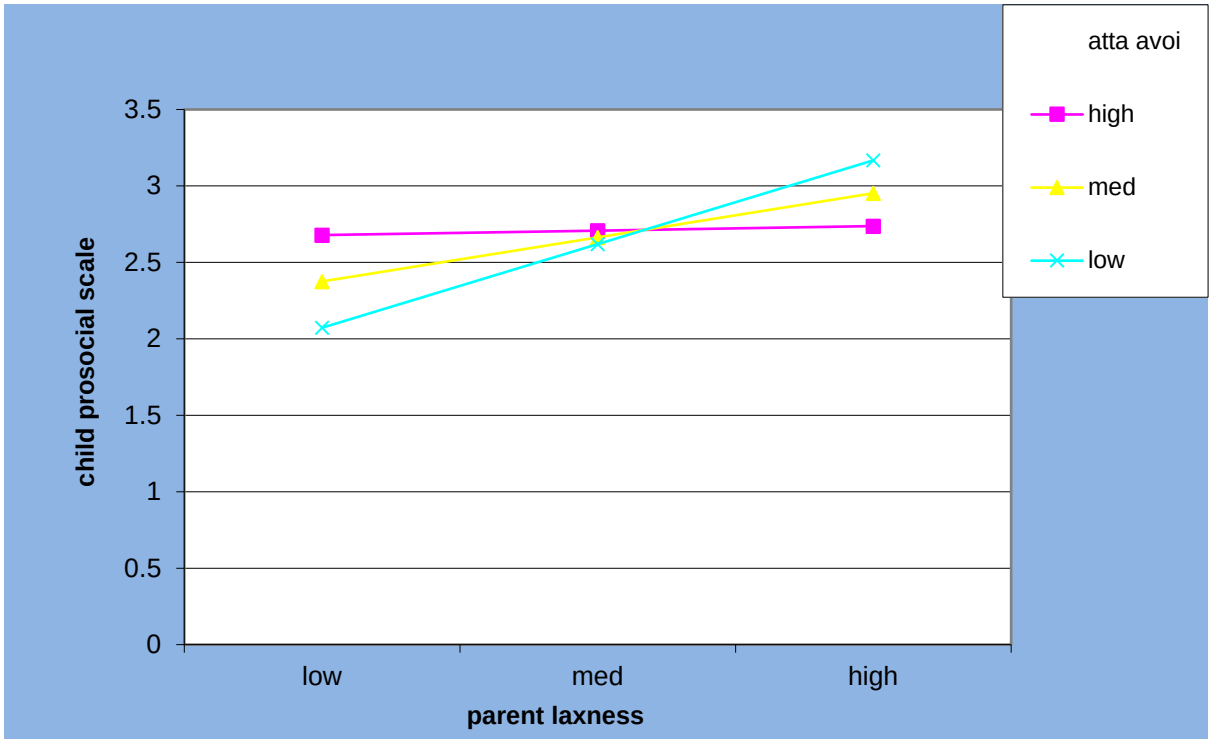


Figure 5.20 shows a moderation effect of parent attachment avoidance in the relationship between parent laxness and child prosocial problem (SDQ-Prosocial). Parent laxness was the independent variable (IV), while SDQ-Prosocial was the dependent variable (DV). The ModGraph indicated that children whose parents had low attachment avoidance presented more prosocial behaviour when those parents also scored low in laxness, while differences in parental attachment avoidance did not have an effect on child prosocial behaviour when parents had high laxness.

Figure 5.21: Parent attachment avoidance as a moderator in the relationship between parent laxness and CSQ-Reexperiencing

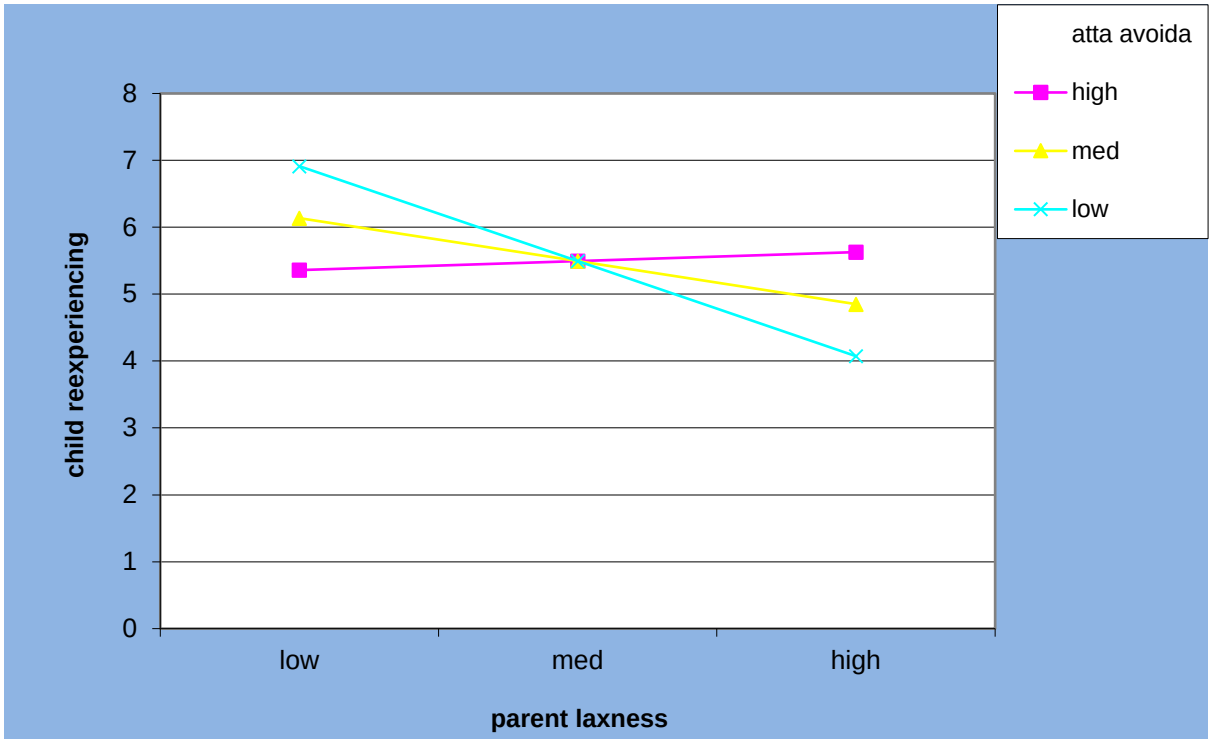


Figure 5.21 shows a moderation effect of parent attachment avoidance in the relationship between parent laxness and child reexperiencing (CSQ-Reexperiencing). Parent laxnesswas the independent variable (IV), while CSQ-Reexperiencing was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment avoidance presented higher reexperiencing when those parents also scored high in laxness, while differences in parental attachment avoidance did not have an effect on child reexperiencing problem when parents had low attachment avoidance.

Figure 5.22: Parent attachment avoidance as a moderator in the relationship between parent laxness and CSQ-Avoidance

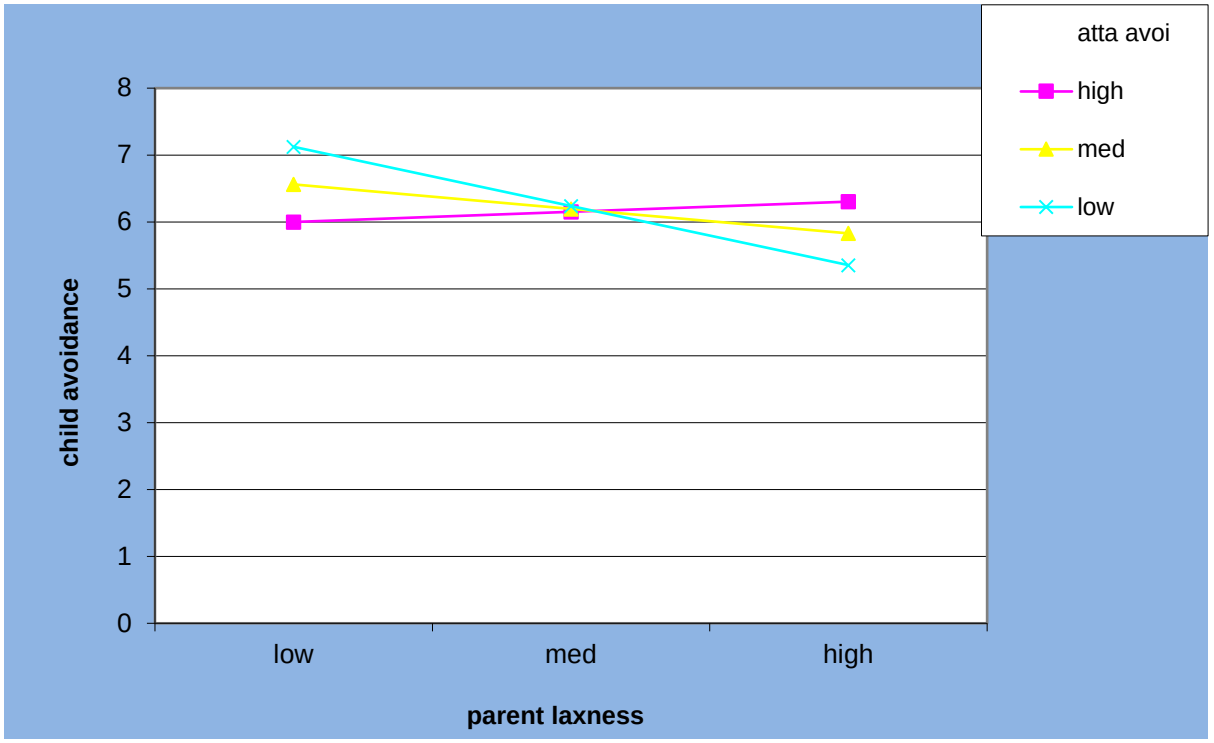


Figure 5.22 shows a moderation effect of parent attachment avoidance in the relationship between parent laxness and child avoidance (CSQ-Avoidance). Parent laxness was the independent variable (IV), while CSQ-Avoidance was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment avoidance presented higher avoidance when those parents also scored high in laxness, while differences in parental attachment avoidance did not have an effect on child avoidance when parents had low laxness.

Figure 5.23: Parent attachment avoidance as a moderator in the relationship between parent laxness and CSQ-Numbing-and-Dissociation

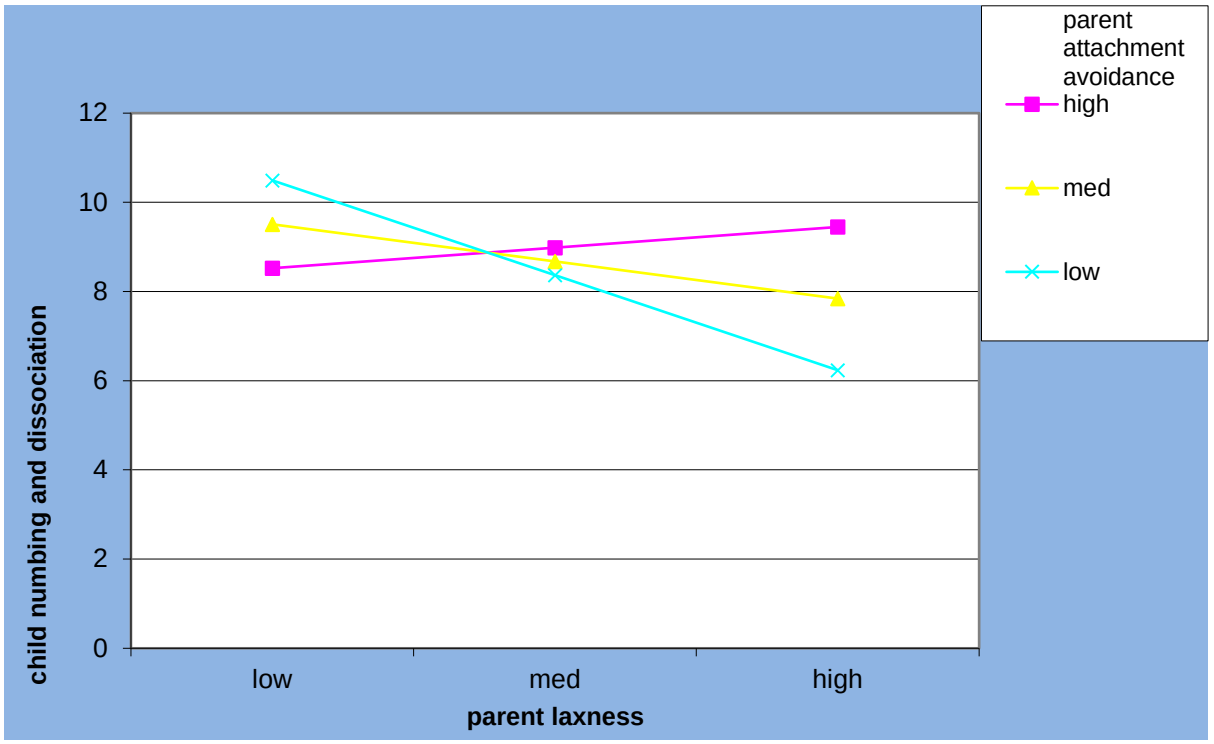


Figure 5.23 shows a moderation effect of parent attachment avoidance in the relationship between parent laxness and child numbing and dissociation (CSQ-Numbing-and-Dissociation). Parent laxness was the independent variable (IV), while CSQ-CSQ-Numbing-and-Dissociation was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment avoidance presented higher numbing and dissociation when those parents also scored high in laxness, while differences in parental attachment avoidance did not have an effect on child numbing and dissociation when parents had low laxness.

Figure 5.24: Parent attachment avoidance as a moderator in the relationship between parent laxness and CSQ-Increased-Arousal

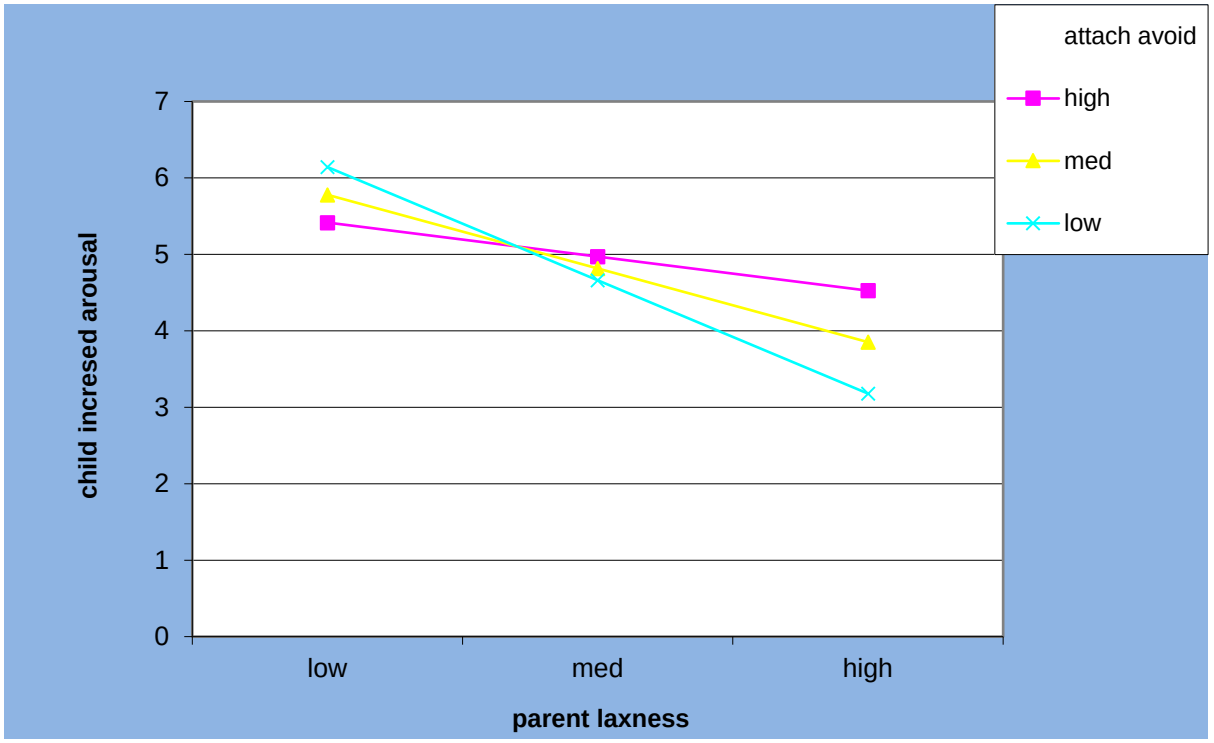


Figure 5.24 shows a moderation effect of parent attachment avoidance in the relationship between parent laxness and child increased arousal (CSQ-Increased-Arousal). Parent laxness was the independent variable (IV), while CSQ-Increased-Arousal was the dependent variable (DV). The ModGraph indicated that children whose parents had higher attachment avoidance presented higher increased arousal when those parents also scored high in laxness, while differences in parental attachment avoidance did not have an effect on child increased arousal when parents had low laxness.

Figure 5.25: Parent attachment avoidance as a moderator in the relationship between parent laxness and CSQ-Impairment-in-Function

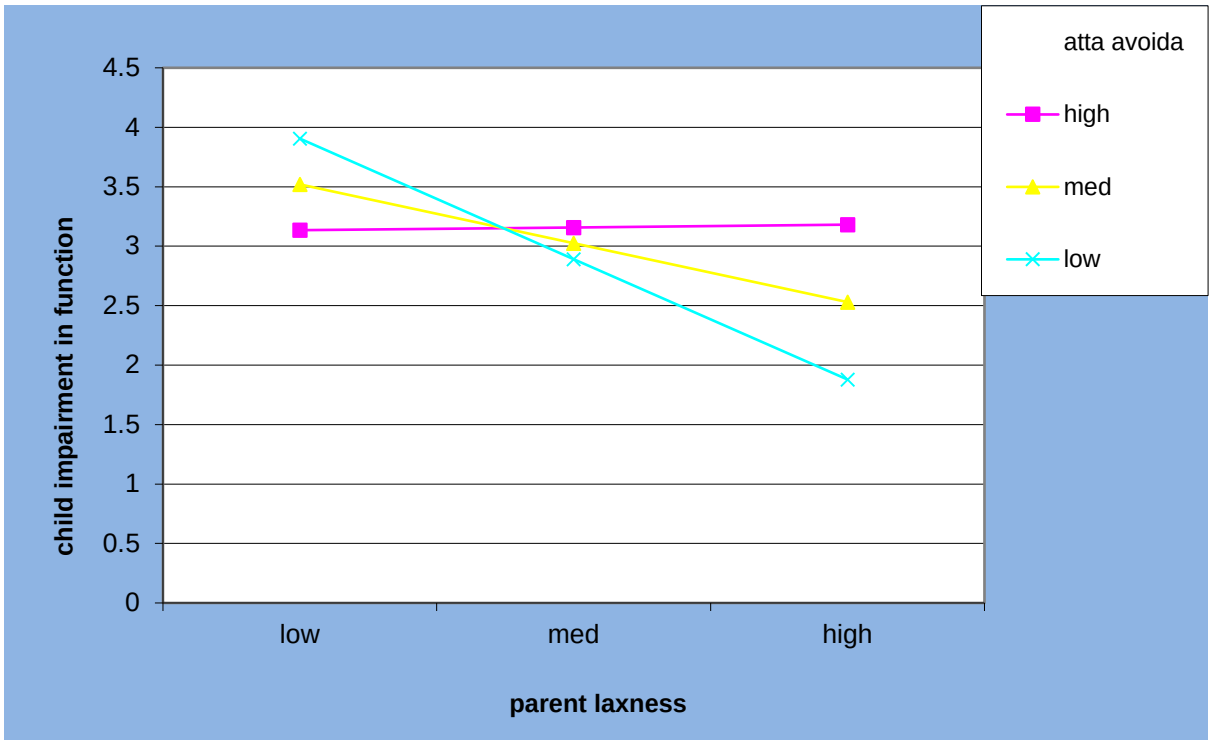


Figure 5.25 shows a moderation effect of parent attachment avoidance in the relationship between parent laxness and child impairment in function (CSQ-Impairment-in-Function). Parent laxness was the independent variable (IV), while CSQ-Impairment-in-Function was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment avoidance presented higher impairment in function when those parents also scored high in laxness, while differences in parental attachment avoidance did not have an effect on child impairment in function when parents had low laxness.

Figure 5.26: Parent attachment anxiety as a moderator in the relationship between parent overreactivity and SDQ-Prosocial

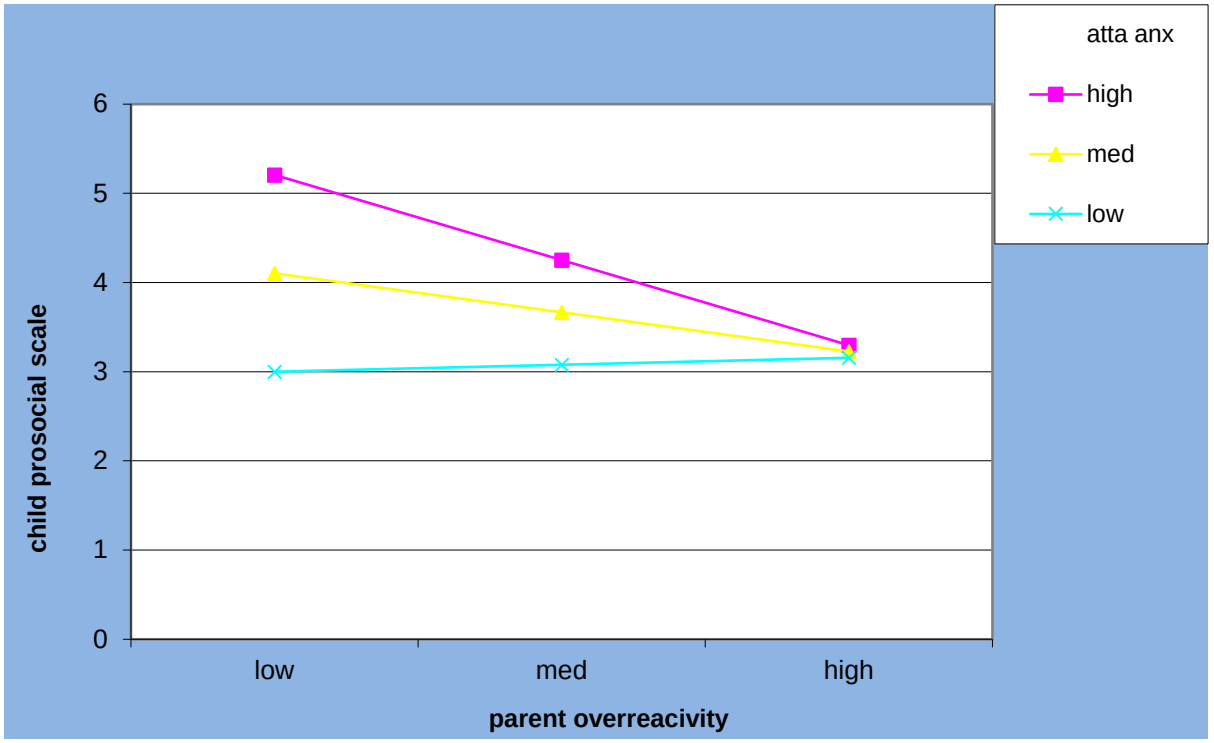


Figure 5.26 shows a moderation effect of parent attachment anxiety in the relationship between parent overreactivity and child prosocial problems (SDQ-Prosocial). Parent overreactivity was the independent variable (IV), while SDQ-Prosocial was the dependent variable (DV). The ModGraph indicated that children whose parents had lower attachment anxiety presented more prosocial behaviour when those parents also scored low in overreactivity, while differences in parental attachment anxiety had no effect on child prosocial behaviour when parents had low overractivity.

Figure 5.27: Parent attachment anxiety as a moderator in the relationship between parent overreactivity and CSQ-Impairment-in-Function

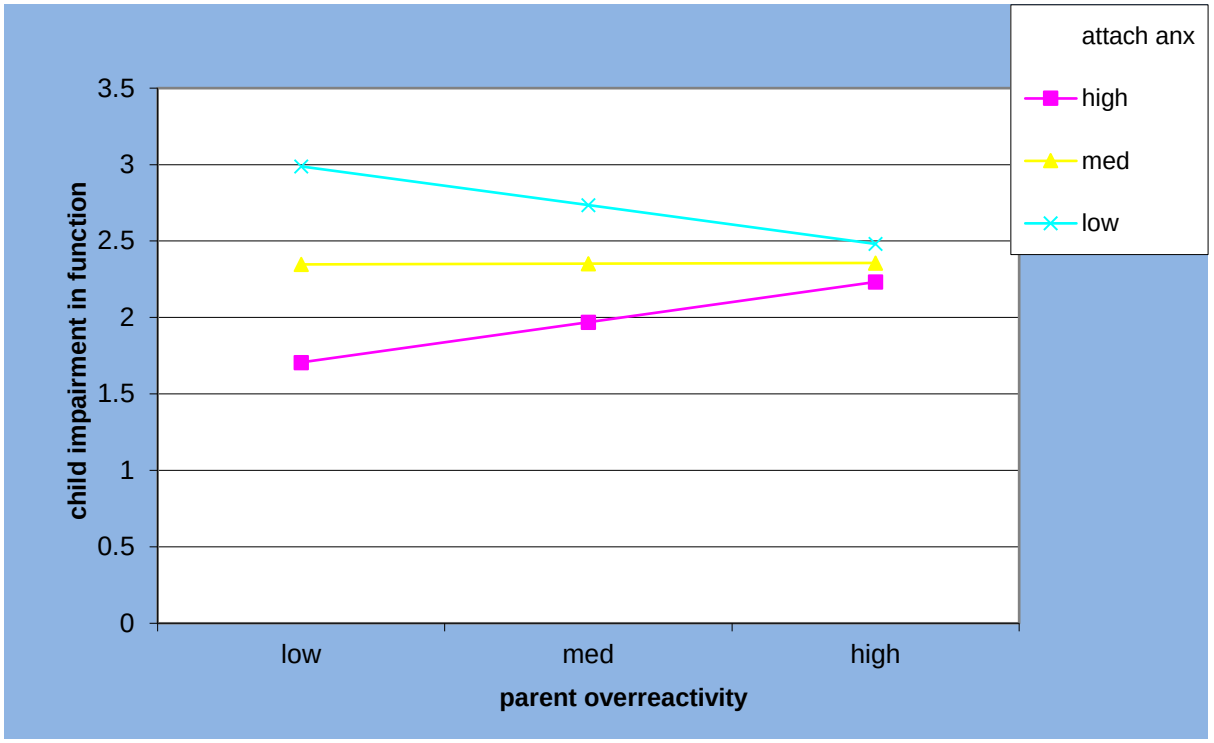


Figure 5.27 shows a moderation effect of parent attachment anxiety in the relationship between parent overreactivity and child impairment in function (CSQ-Impairment-in-Function). Parent overreactivity was the independent variable (IV), while CSQ-Impairment-in-Function was the dependent variable (DV). The ModGraph indicated that children whose parents had low attachment anxiety presented higher impairment in function when those parents also scored low in overreactivity, while differences in parental attachment anxiety had no effect on child impairment in function when parents had high overractivity.

Figure 5.28: Parent attachment avoidance as a moderator in the relationship between parent overreactivity and SDQ-Prosocial

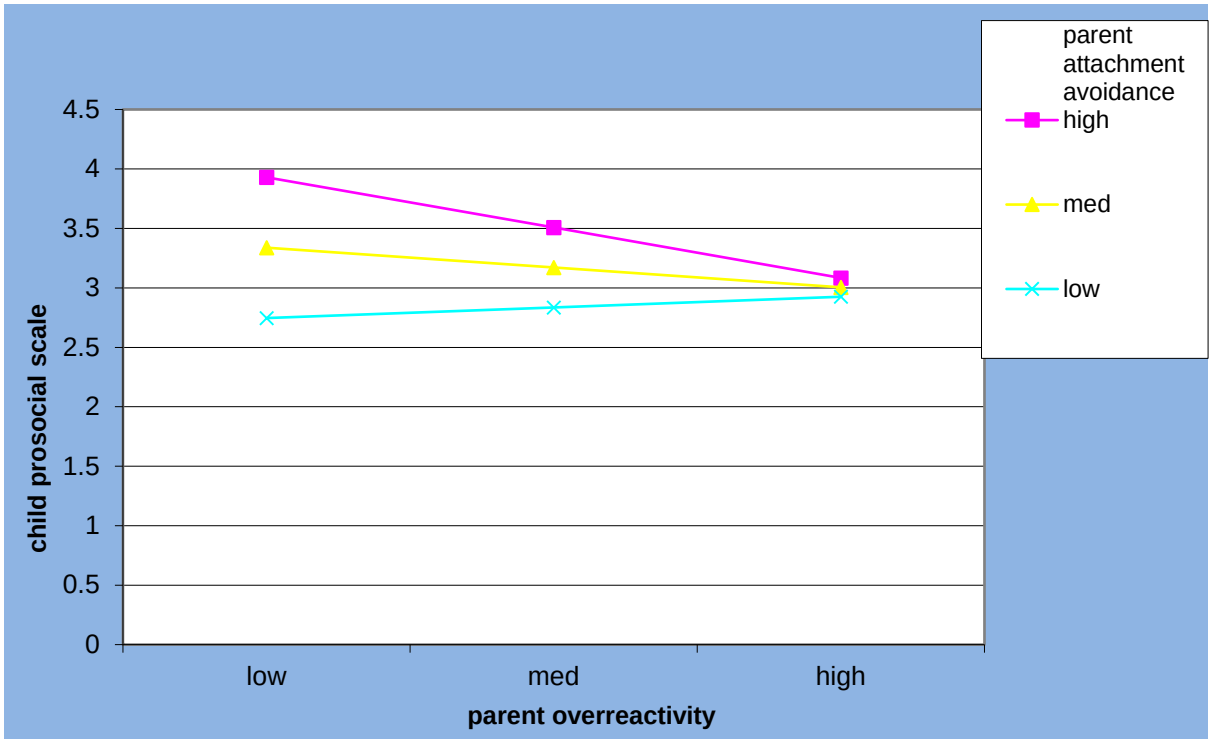


Figure 5.28 shows a moderation effect of parent attachment avoidance in the relationship between parent overreactivity and prosocial problem (SDQ-Prosocial). Parent overreactivity was the independent variable (IV), while SDQ-Prosocial was the dependent variable (DV). The ModGraph indicated that children whose parents had lower attachment avoidance presented lower prosocial behaviour when those parents also scored high in overreactivity, while differences in parental attachment avoidance had no effect on child prosocial behaviour when parents had high overractivity.

Figure 5.29: Parent attachment anxiety as a moderator in the relationship between parent verbosity and SDQ-Emotional-Problem

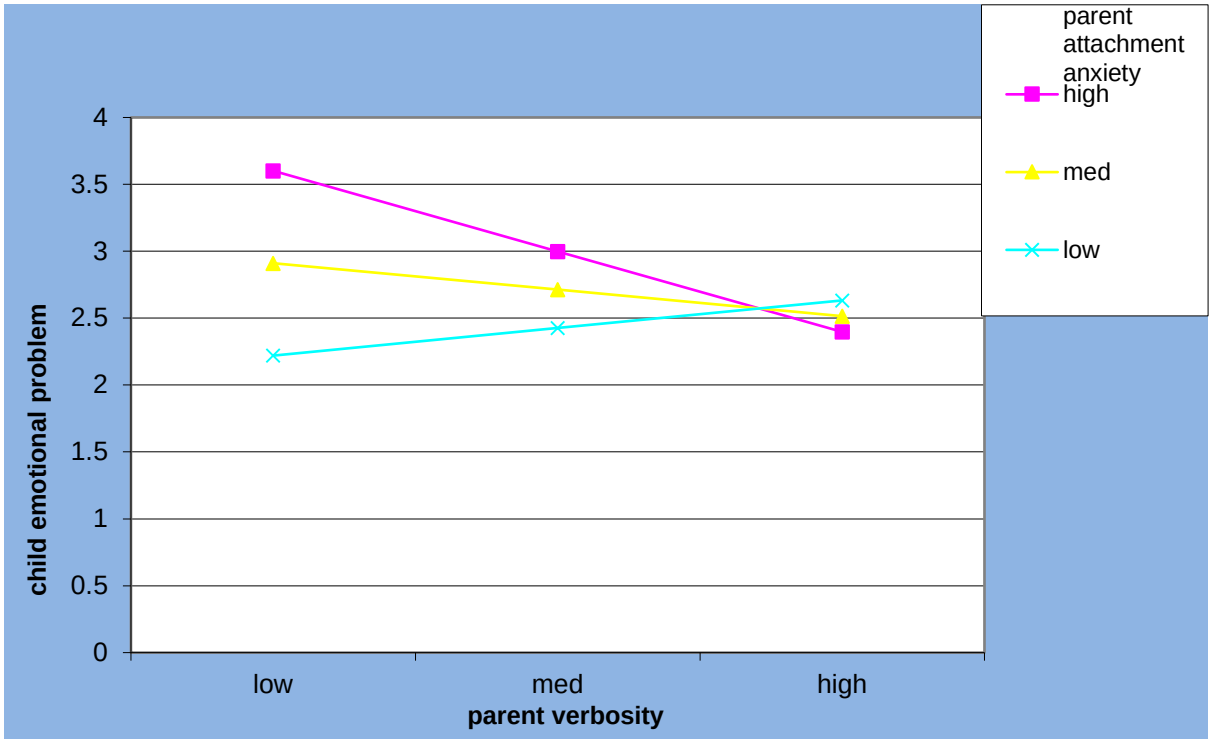


Figure 5.29 shows a moderation effect of parent attachment anxiety in the relationship between parent verbosity and emotional problem (SDQ-Emotional-Problem). Parent verbosity was the independent variable (IV), while SDQ-Emotional-Problem was the dependent variable (DV). The ModGraph indicated that children whose parents had lower attachment anxiety presented higher emotional problem when those parents also scored low in verbosity, while differences in parental attachment anxiety had no effect on child emotional problems when parents had high verbosity.

Figure 5.30: Parent attachment anxiety as a moderator in the relationship between parent verbosity and SDQ-Prosocial

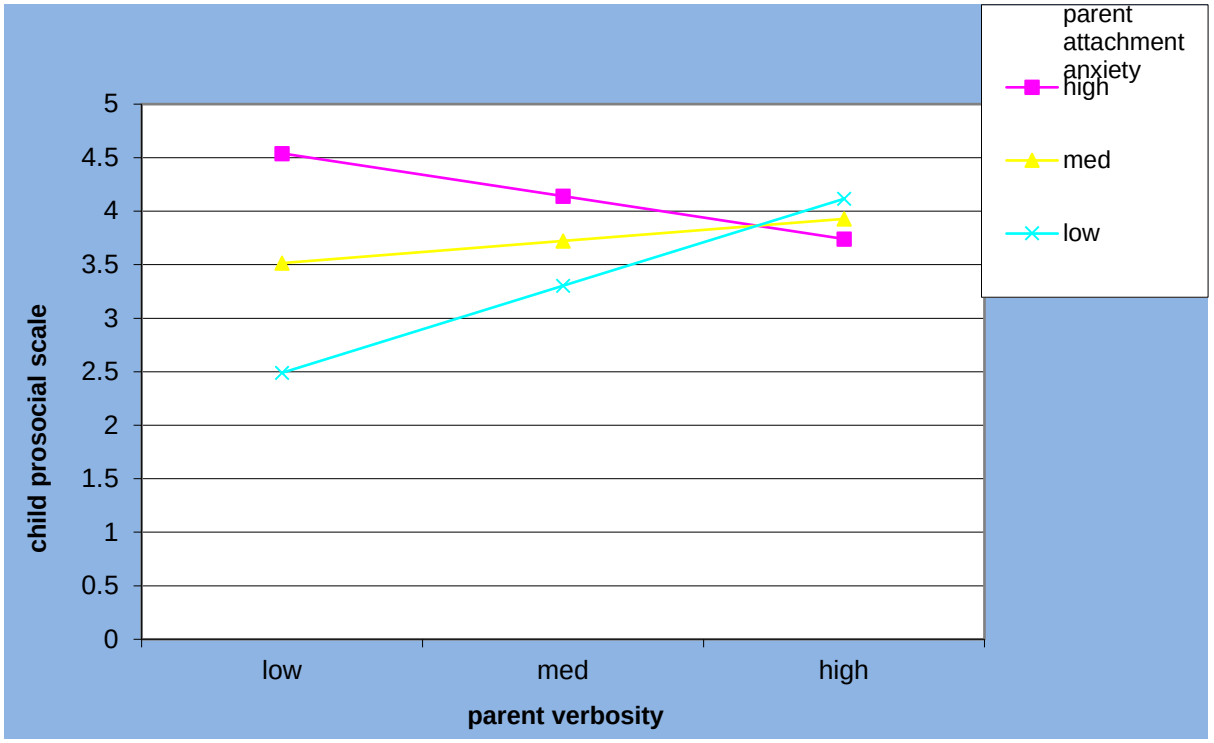


Figure 5.30 shows a moderation effect of parent attachment anxiety in the relationship between parent verbosity and prosocial problem (SDQ-Prosocial). Parent verbosity was the independent variable (IV), while SDQ-Prosocial was the dependent variable (DV). The ModGraph indicated that children whose parents low high attachment anxiety presented more prosocial behaviour when those parents also scored low in verbosity, while differences in parental verbosity had no effect on child prosocial behaviour when parents had high verbosity.

Figure 5.31: Parent attachment anxiety as a moderator in the relationship between parent verbosity and CSQ-Avoidance

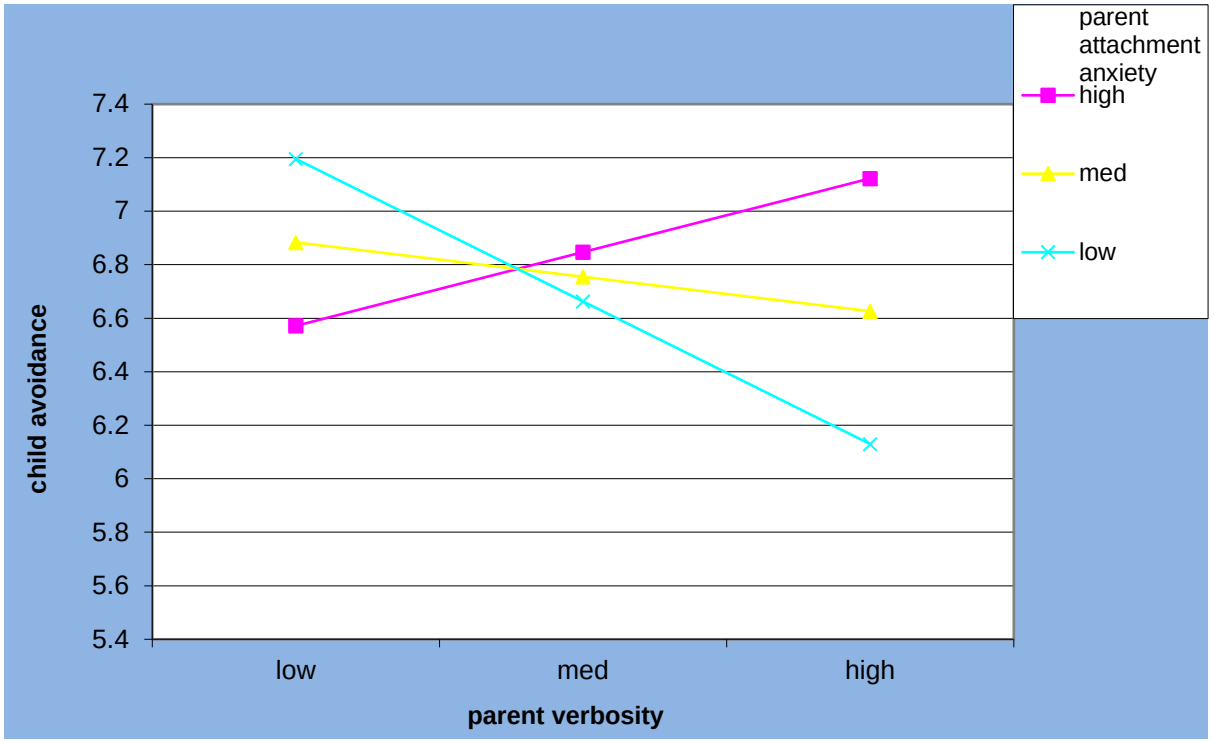


Figure 5.31 shows a moderation effect of parent attachment anxiety in the relationship between parent verbosity and child avoidance (CSQ-Avoidance). Parent verbosity was the independent variable (IV), while CSQ-Avoidance was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment anxiety presented higher avoidance when those parents also scored high in verbosity, while differences in parental attachment anxiety did not have an effect on child avoidance when parents had low verbosity.

Figure 5.32: Parent attachment anxiety as a moderator in the relationship between parent verbosity and CSQ-Numbing-and-Dissociation

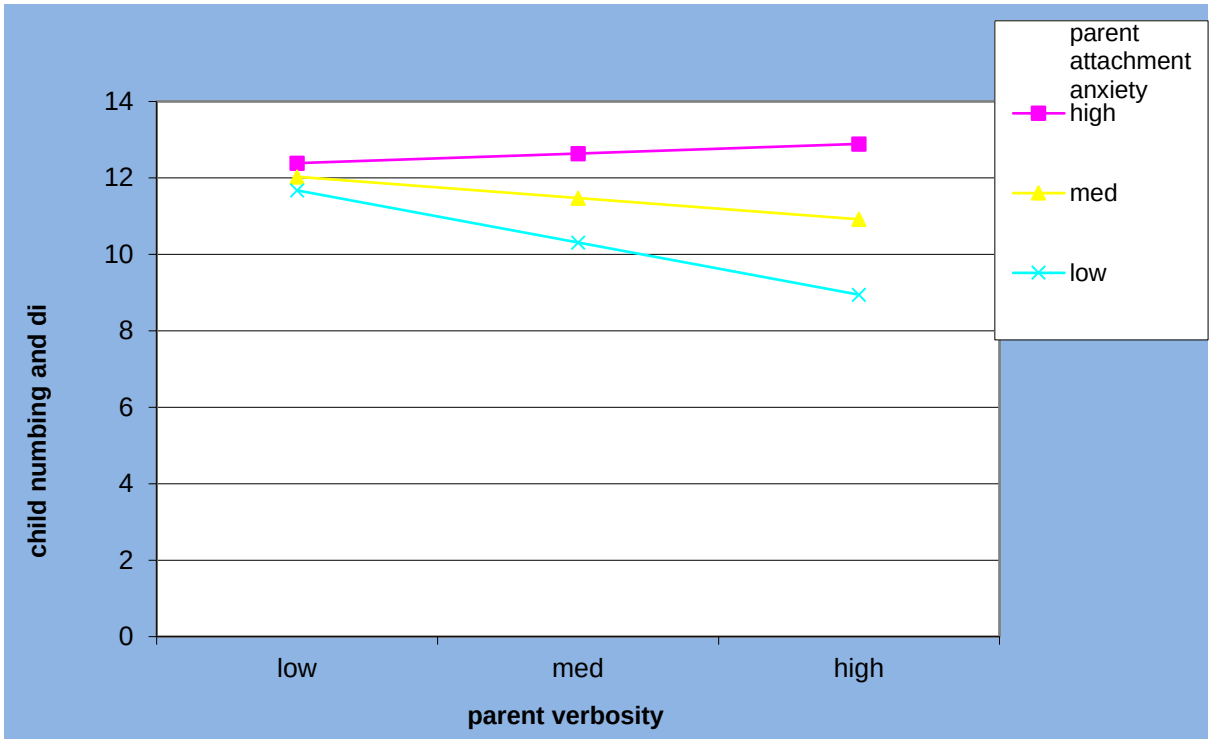


Figure 5.32 shows a moderation effect of parent attachment anxiety in the relationship between parent verbosity and child numbing and dissociation (CSQ-Numbing-and-Dissociation). Parent verbosity was the independent variable (IV), while CSQ-Numbing-and-Dissociation was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment anxiety presented higher numbing and dissociation when those parents also scored high in verbosity, while differences in parental attachment anxiety had no effect on child numbing and dissociation when parents had low verbosity.

Figure 5.33: Parent attachment avoidance as a moderator in the relationship between parent verbosity and SDQ-Prosocial

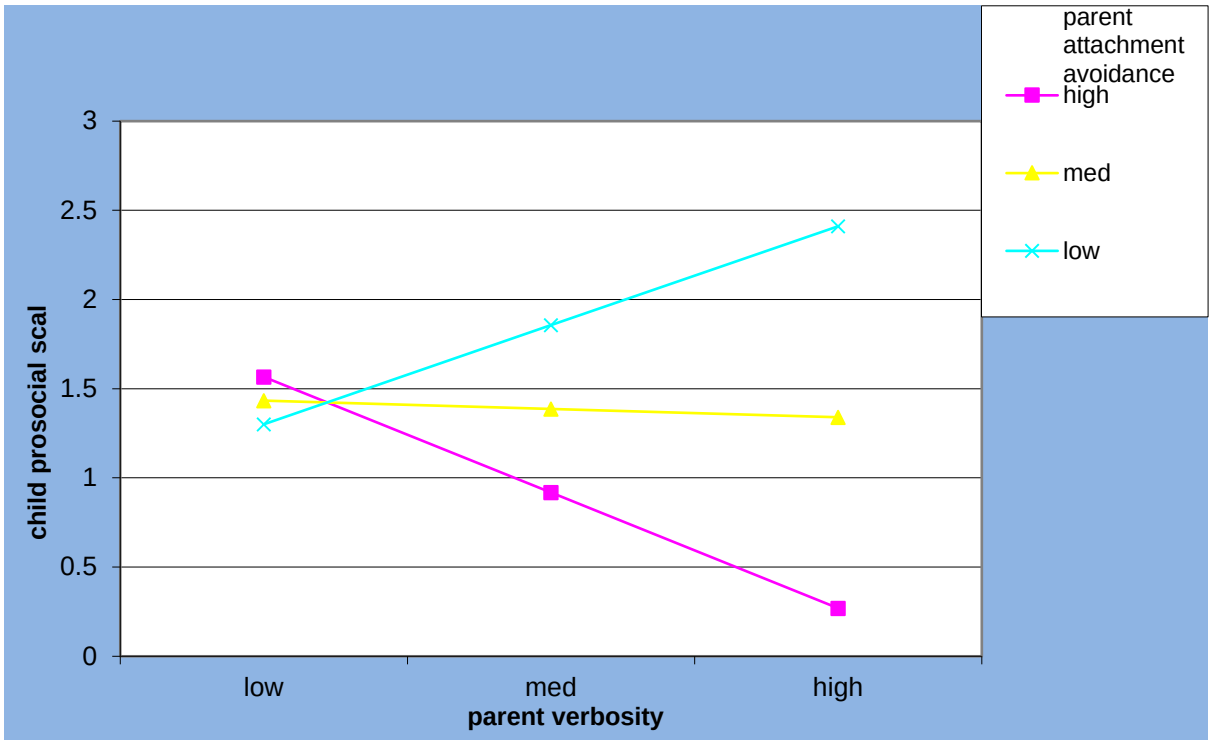


Figure 5.33 shows a moderation effect of parent attachment avoidance in the relationship between parent verbosity and child prosocial problem (SDQ-Prosocial). Parent verbosity was the independent variable (IV), while SDQ-Prosocial was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment avoidance presented less prosocial behaviour when those parents also scored high in verbosity, while differences in parental avoidance had no effect on the child's prosocial behaviour when parents had low verbosity.

Figure 5.34: Parent attachment avoidance as a moderator in the relationship between parent verbosity and CSQ-Reexperiencing

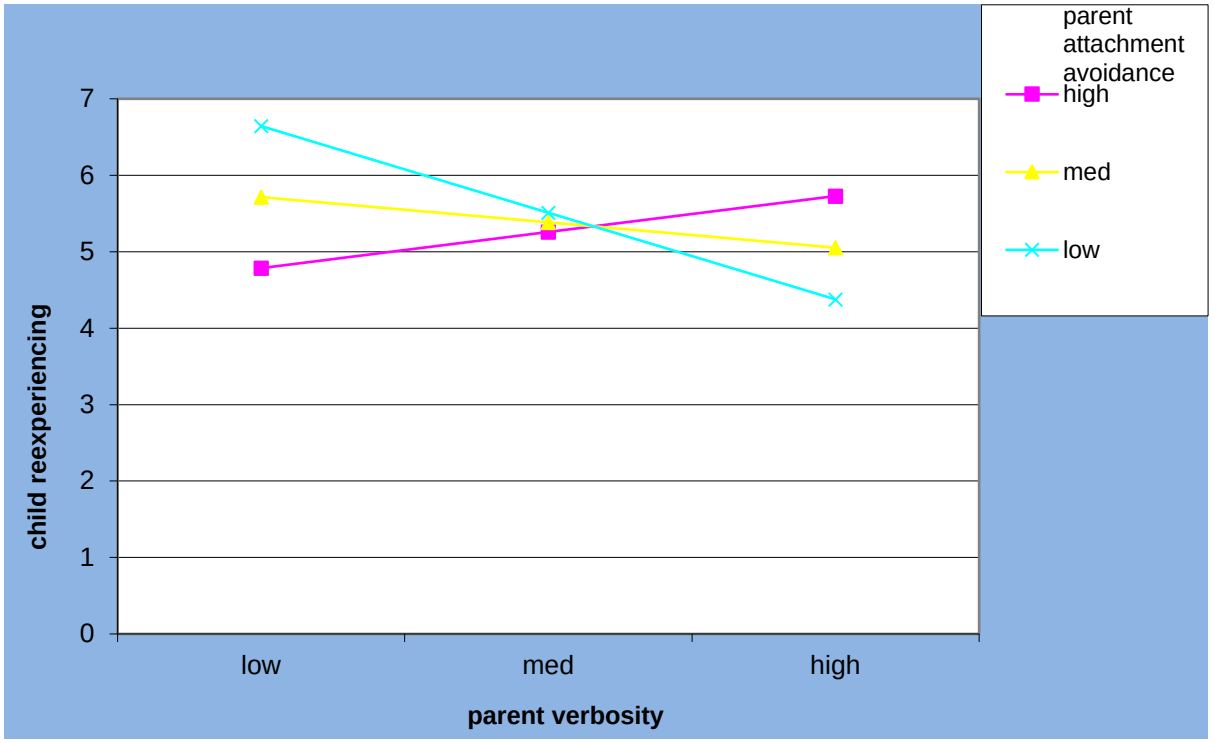


Figure 5.34 shows a moderation effect of parent attachment avoidance in the relationship between parent verbosity and child reexperiencing (CSQ-Reexperiencing). Parent verbosity was the independent variable (IV), while CSQ-Reexperiencing was the dependent variable (DV). The ModGraph indicated that children whose parents had higher attachment avoidance presented lower reexperiencing when those parents also scored lower in verbosity, while differences in parental avoidance did not have an effect on child reexperiencing when parents had high verbosity.

Figure 5.35: Parent attachment avoidance as a moderator in the relationship between parent verbosity and CSQ-Avoidance

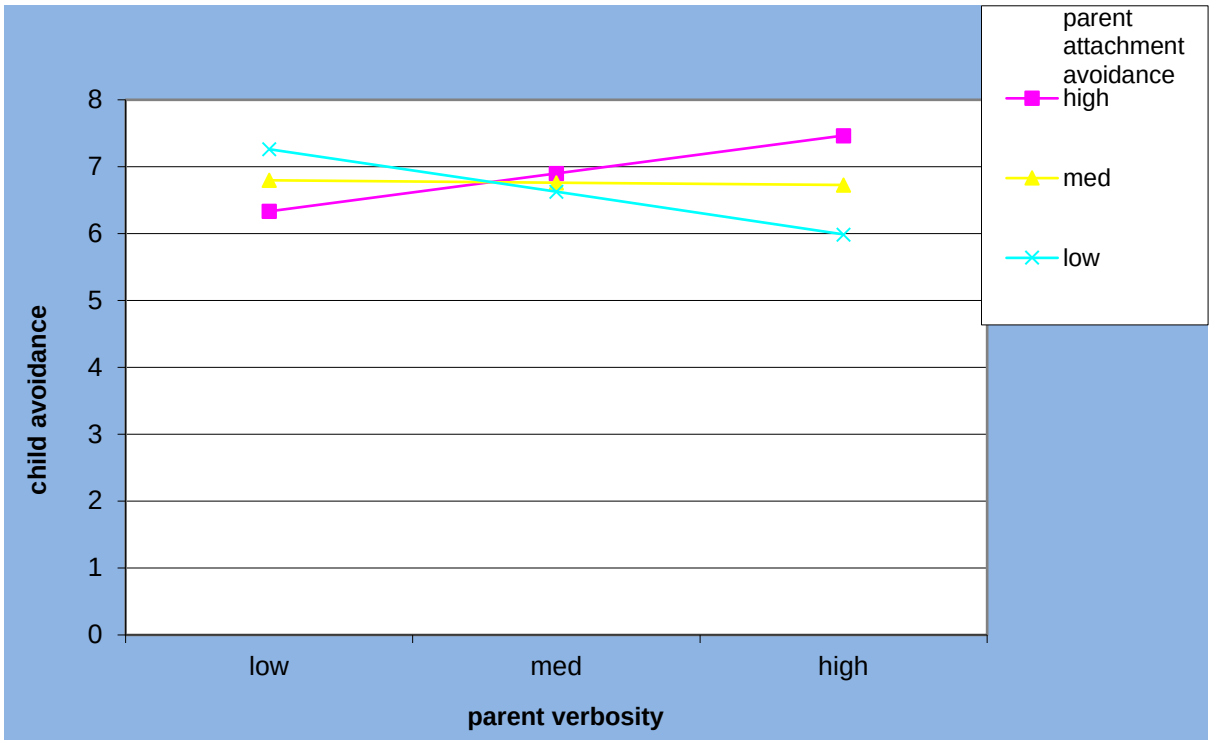


Figure 5.35 shows a moderation effect of parent attachment avoidance in the relationship between parent verbosity and child avoidance (CSQ-Avoidance). Parent verbosity was the independent variable (IV), while CSQ-Avoidance was the dependent variable (DV). The ModGraph indicated that children whose parents had high attachment avoidance presented higher avoidance when those parents also scored high in verbosity, while differences in parental attachment avoidance did not have an effect on child avoidance when parents had low verbosity.

Figure 5.36: Parent attachment avoidance as a moderator in the relationship between parent verbosity and CSQ-Numbing-and-Dissociation

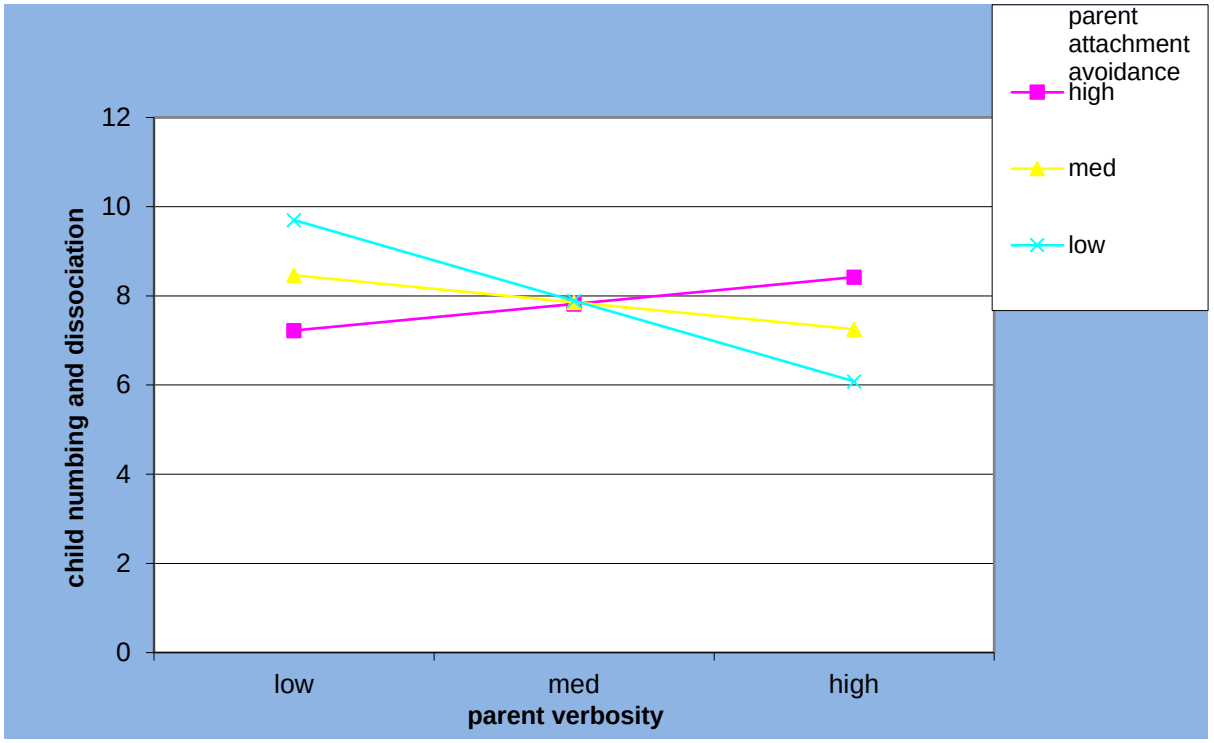


Figure 5.36 shows a moderation effect of parent attachment avoidance in the relationship between parent verbosity and child numbing and dissociation (CSQ-Numbing-and-Dissociation). Parent verbosity was the independent variable (IV), while CSQ-Numbing-and-Dissociation was the dependent variable (DV). The ModGraph indicated that children whose parents had higher attachment avoidance presented higher numbing and dissociation when those parents also scored high in verbosity, while differences in parental avoidance did not have a significant effect on child numbing and dissociation when parents had low verbosity.

Figure 5.37: Parent attachment avoidance as a moderator in the relationship between parent verbosity and CSQ-Increased-Arousal

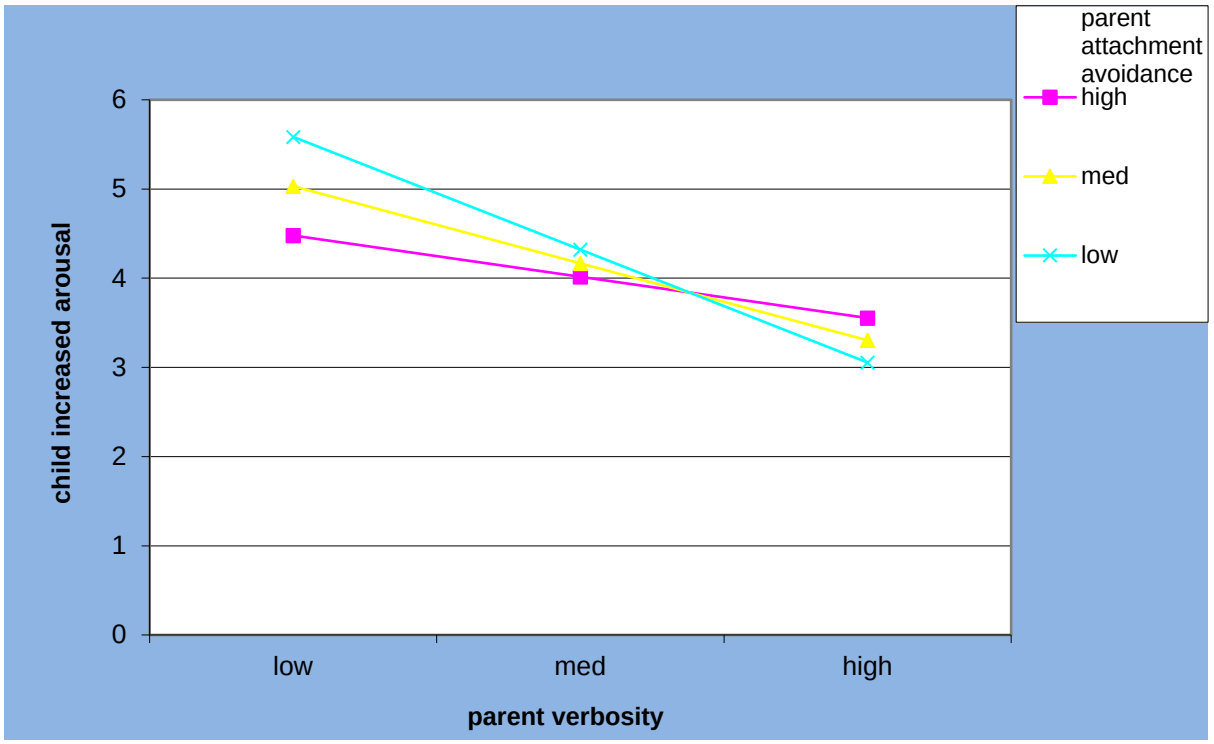


Figure 5.37 shows a moderation effect of parent attachment avoidance in the relationship between parent verbosity and child increased arousal (CSQ-Increased-Arousal). Parent verbosity was the independent variable (IV), while CSQ-Increased-Arousal was the dependent variable (DV). The ModGraph indicated that children whose parents had lower attachment avoidance presented higher increased arousal when those parents also scored low in verbosity, while differences in parental avoidance did not have an effect on child increased arousal when parents had high verbosity.

Figure 5.38: Parent attachment avoidance as a moderator in the relationship between parent verbosity and CSQ-Impairment-in-Function

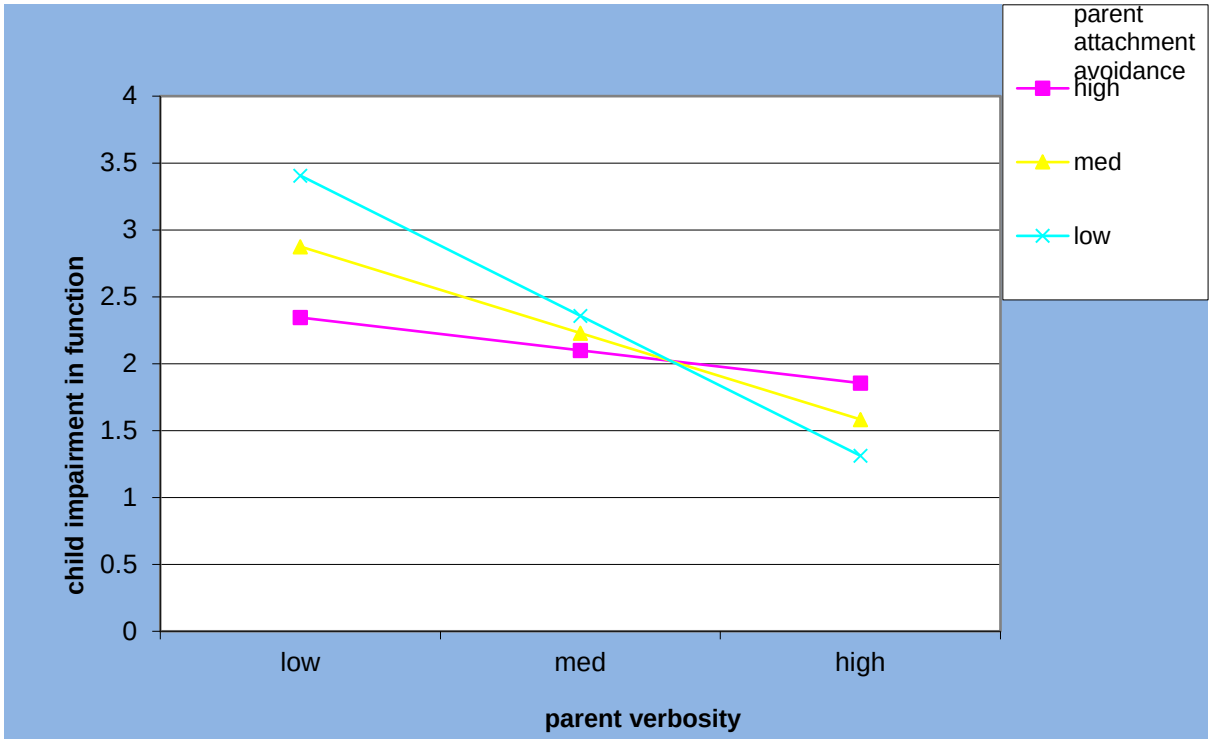


Figure 5.38 shows a moderation effect of parent attachment avoidance in the relationship between parent verbosity and child impairment in function (CSQ-Impairment-in-Function). Parent verbosity was the independent variable (IV), while CSQ-Impairment-in-Function was the dependent variable (DV). The ModGraph indicated that children whose parents had low attachment avoidance presented higher impairment in function when those parents also scored low in verbosity, while differences in parental avoidance did not have an effect on child impairment in function when parents had high verbosity.

Finally, hypothesis 9 was also tested in the non-bereaved sample. Parenting style was put as IV, child-problems (SDQ) as DV, while parent-age, parent-gender, ECR-Avoidance (ECR-Anxiety in the second analysis), and parent-complicated-grief were controlled for. The results showed that parent attachment style did not

moderate the relationship between parenting style and behavioural problems among the non-bereaved children.

Hypothesis 10

Firstly, to address hypothesis 10 I ran a Hierarchical multiple linear regression analysis in the bereaved sample. Parenting style was put as IV, child-problems (SDQ and CSQ) as DV, while parent-age, parent-gender, ECR-Avoidance, and ECR-Anxiety were controlled for. In the first step controlled variables were entered, in the second step parenting styles (PS-Laxness, PS-Overreactivity, and PS-Verbosity in three analyses, respectively) and the moderator, parent-complicated-grief were entered and in the final step the interaction parent-complicated-griefXPS-Laxness (parent-complicated-griefXPS-Overreactivity and parent-complicated-griefXPS-Verbosity in the second and third analyses, respectively) was added.

The results showed that parent-complicated-grief moderated the relationship between parenting style and behavioural problems among the bereaved children (see Appendix V Tables 19–23). Specifically, parent-complicated-grief moderated the impact of PS-Laxness on CSQ-Numbing-Dissociation and CSQ-Impairment-in-Function while on CSQ-Avoidance marginally significant. Additionally it moderated the link between PS-Overreactivity and child SDQ-Hyperactivity, SDQ-Prosocial, and CSQ- Immediate-Response; moreover, parent-complicated-grief moderated an impact of PS-Verbosity on SDQ-Prosocial, CSQ-Numbing-and-Dissociation, and CSQ-Impairment-in-Function while marginally significant to CSQ-Immediate-Response and CSQ-Avoidance.

Figure 5.39: Parent-complicated-grief as a moderator in the relationship between PS-Laxness and CSQ-Numbing-and-Dissociation

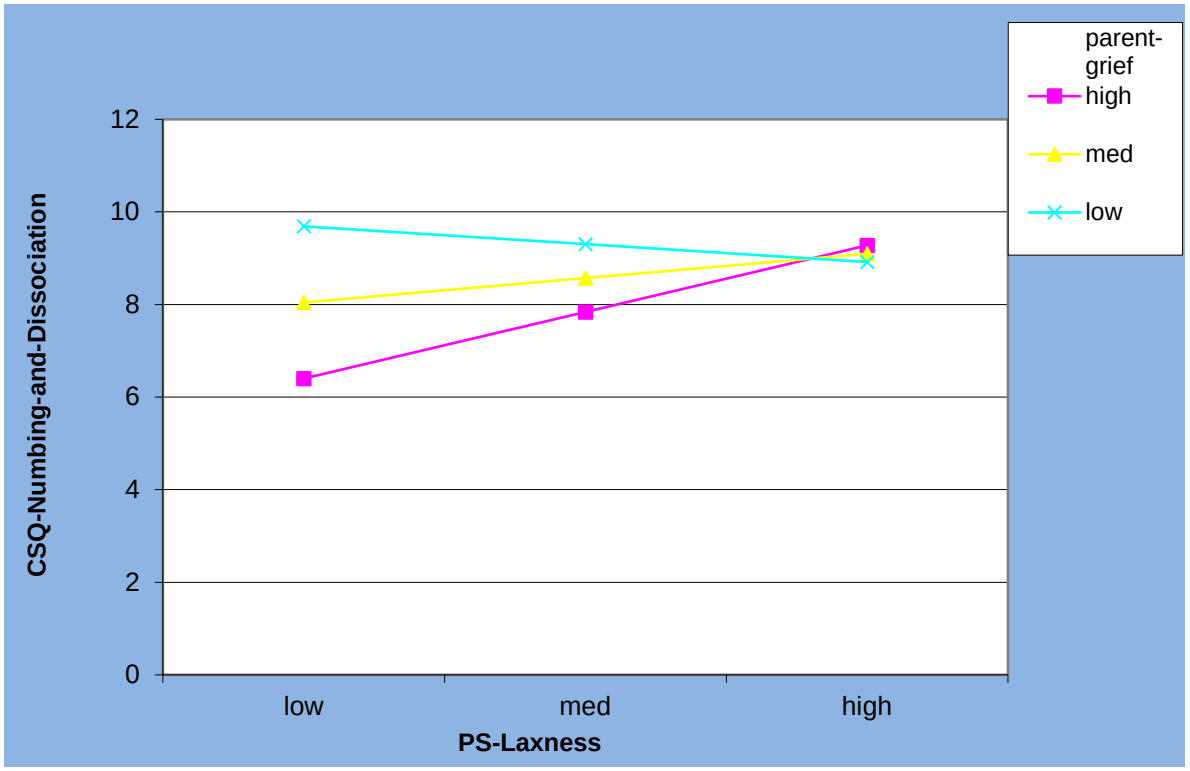


Figure 5.39 shows a moderation effect of parent-complicated-grief in the relationship between parent laxness and child numbing and dissociation (CSQ-Numbing-and-Dissociation). Parent laxness was the independent variable (IV), while CSQ- Numbing-and-Dissociation was the dependent variable (DV). The ModGraph indicated that children whose parents had low laxness presented higher numbing and dissociation when those parents also scored low in complicated grief, while differences in parental grief had no effect on child numbing and dissociation when parents had high laxness.

Figure 5.40: Parent-complicated-grief as a moderator in the relationship between PS-Laxness and CSQ-Impairment-in-Function

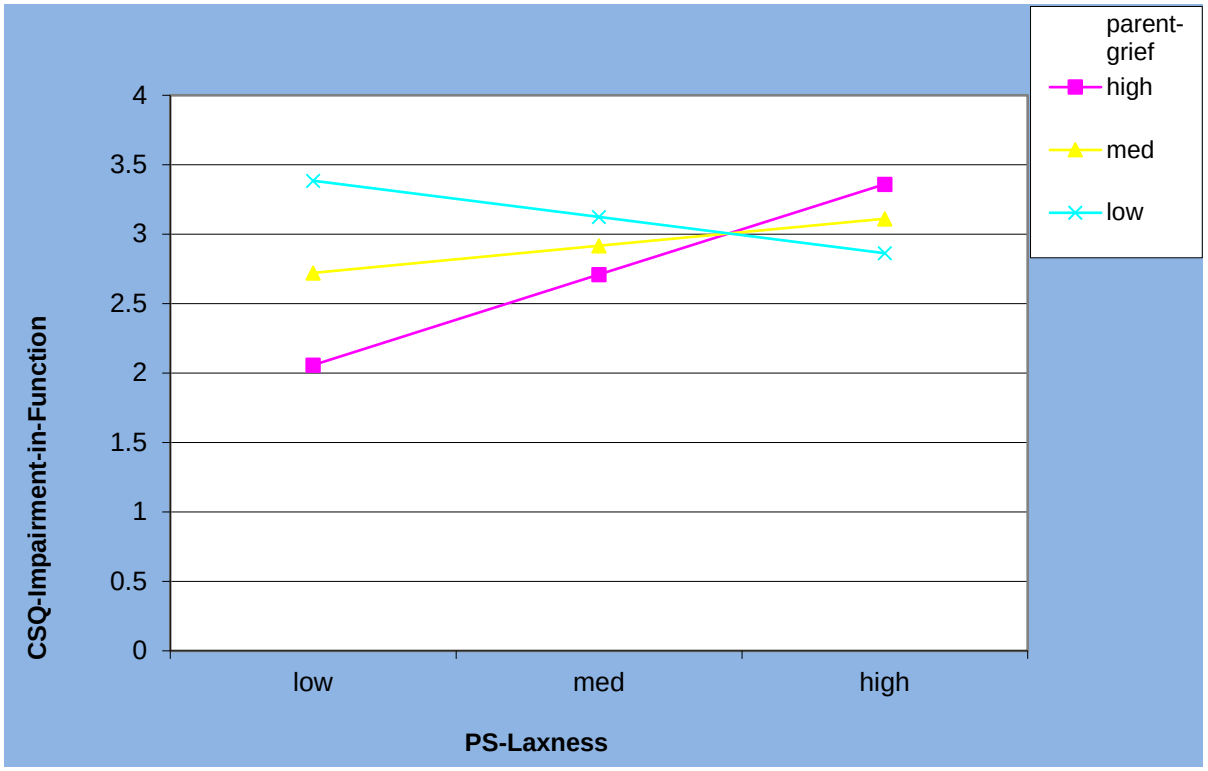


Figure 5.40 shows a moderation effect of parent-complicated-grief in the relationship between parent laxness and child impairment in function (CSQ-Impairment-in-Function). Parent laxness was the independent variable (IV), while CSQ-Impairment-in-Function was the dependent variable (DV). The ModGraph indicated that children whose parents had low laxness presented higher impairment in function when those parents also scored low in complicated grief, while differences in parental grief had no effect on child impairment in function when parents had high laxness. Additionally the results showed that parent-complicated-grief moderated the link between PS-Overreactivity and child SDQ-Hyperactivity, SDQ-Prosocial, and CSQ-Immediate-Response.

Figure 5.41: Parent-complicated-grief as a moderator in the relationship between PS-Overreactivity and SDQ-Hyperactivity

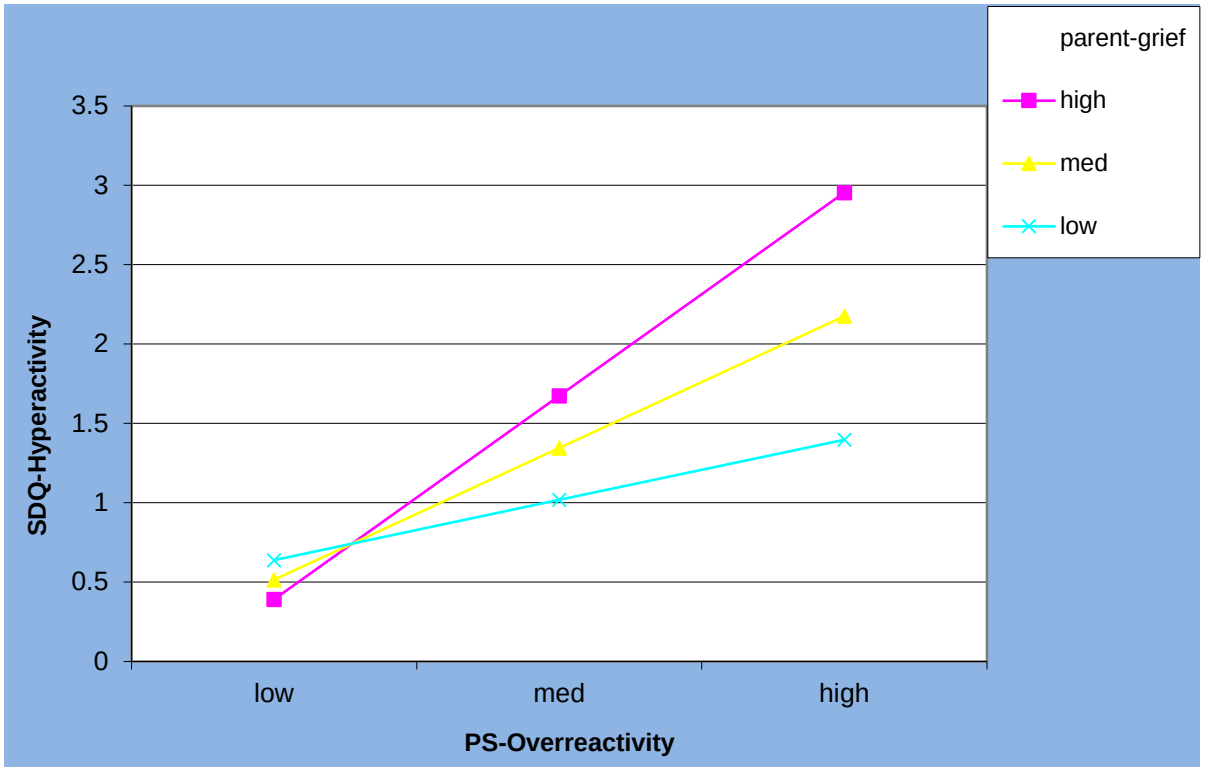


Figure 5.41 shows a moderation effect of parent-complicated-grief in the relationship between parent overreactivity and child hyperactivity (SDQ-Hyperactivity). Parent-Overreactivity was the independent variable (IV), while SDQ-Hyperactivity was the dependent variable (DV). The ModGraph indicated that children whose parents had high overreactivity presented higher hyperactivity when those parents also scored high in complicated grief, while differences in parental grief had no effect on child hyperactivity when parents had low overreactivity.

Figure 5.42: Parent-complicated-grief as a moderator in the relationship between PS-Overreactivity and SDQ-Prosocial

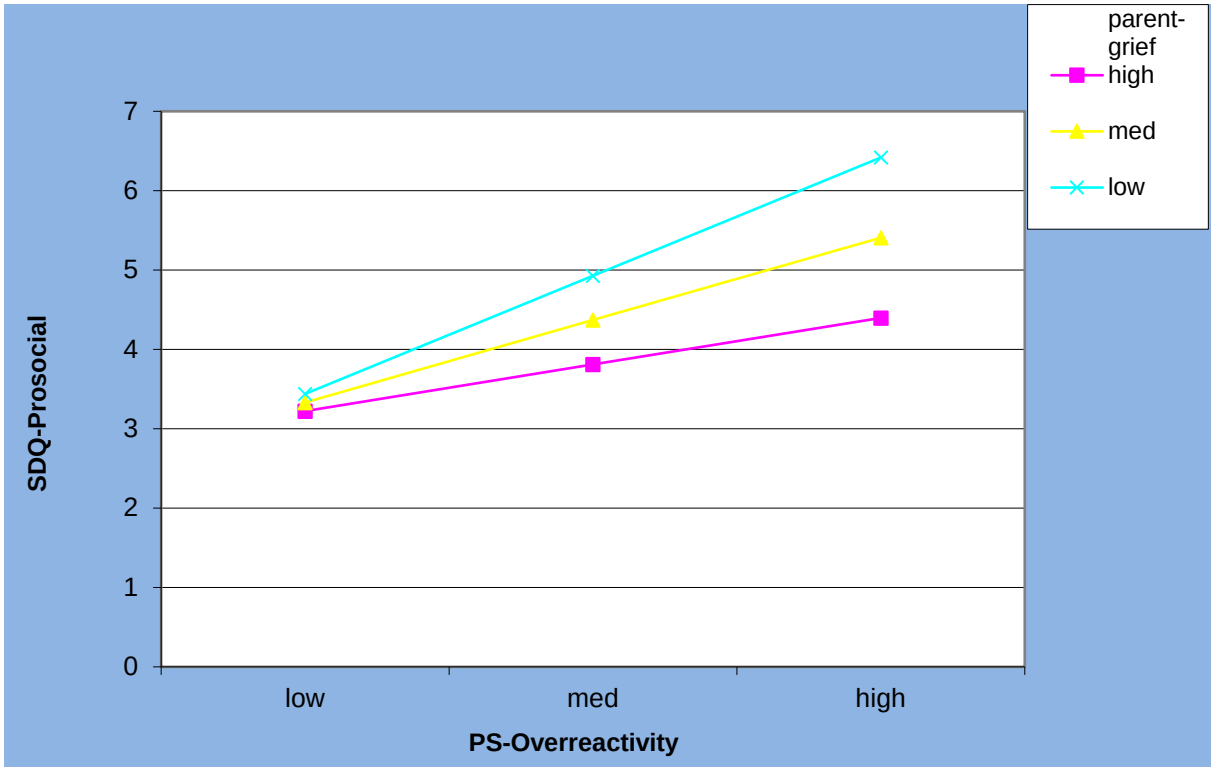


Figure 5.42 shows a moderation effect of parent-complicated-grief in the relationship between parent overreactivity and child prosocial behaviour (SDQ-Prosocial). Parent-Overreactivity was the independent variable (IV), while SDQ-Prosocial was the dependent variable (DV). The ModGraph indicated that children whose parents had high overreactivity presented less prosocial behaviour when those parents also scored high in complicated grief, while differences in parental grief had no effect on child prosocial behaviour when parents had low overreactivity.

Figure 5.43: Parent-complicated-grief as a moderator in the relationship between PS-Overreactivity and CSQ-Immediate-Response

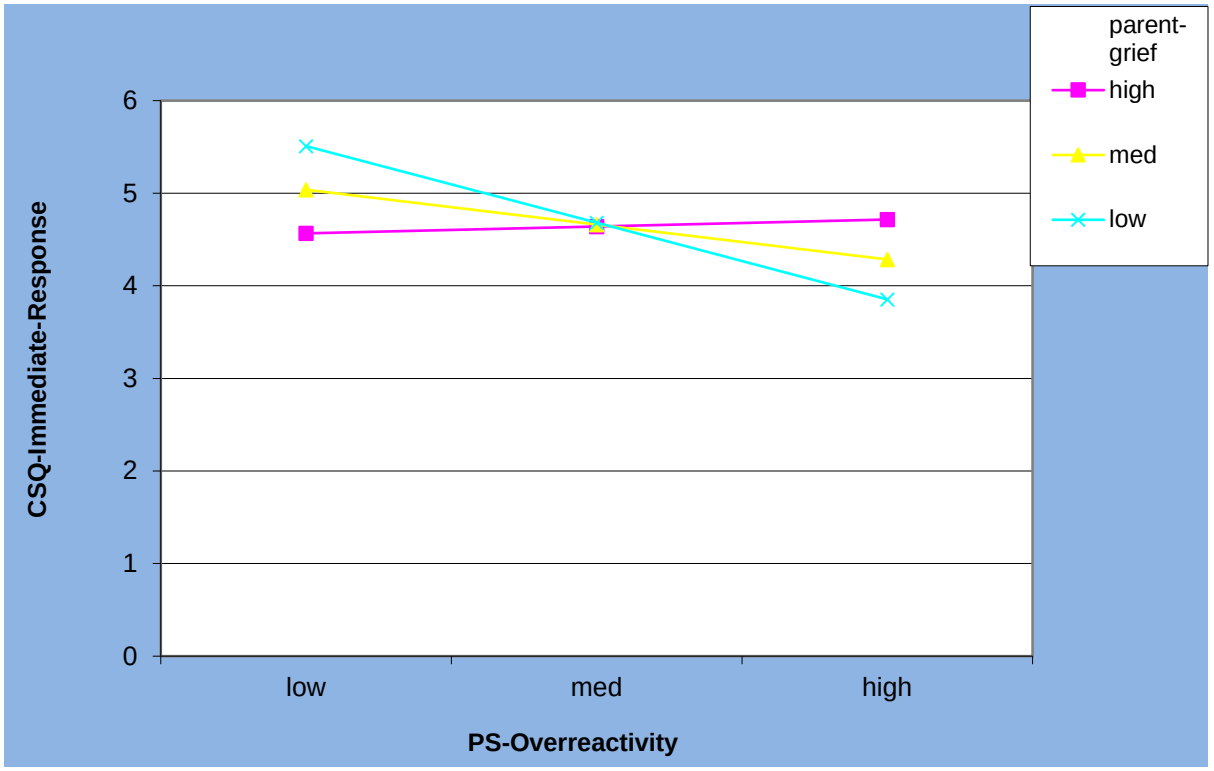


Figure 5.43 shows a moderation effect of parent-complicated-grief in the relationship between parent overreactivity and child immediate response (CSQ-Immediate-Response). Parent-Overreactivity was the independent variable (IV), while CSQ-Immediate-Response was the dependent variable (DV). The ModGraph indicated that children whose parents had high overreactivity presented higher immediate response when those parents also scored high in parent grief, while differences in parental grief did not have an effect on child immediate response when parents had low overreactivity. Moreover, parent-complicated-grief moderated an impact of PS-Verbosity on SDQ-Prosocial, CSQ-Numbing-and-Dissociation, and CSQ-Impairment-in-Function while marginally non-significant to CSQ-Immediate-Response and CSQ-Avoidance.

Figure 5.44: Parent-complicated-grief as a moderator in the relationship between PS-Verbosity and SDQ-Prosocial

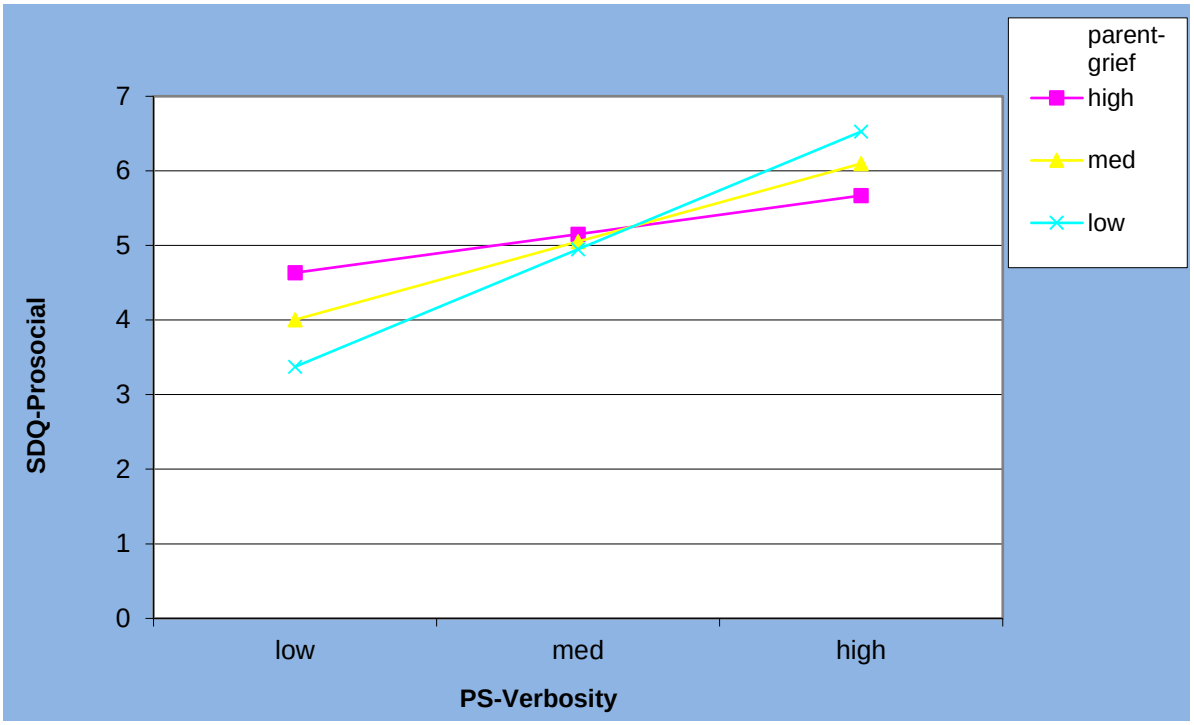


Figure 5.44 shows a moderation effect of parent-complicated-grief in the relationship between parent verbosity and child prosocial problem (SDQ-Prosocial). PS-Verbosity was the independent variable (IV), while SDQ-Prosocial was the dependent variable (DV). The ModGraph indicated that children whose parents had lower verbosity presented lower prosocial behaviour when those parents also scored low in complicated grief, while differences in parental grief did not have an effect on child prosocial problem when parents had high verbosity.

Figure 5.45: Parent-complicated-grief as a moderator in the relationship between PS-Verbosity and CSQ-Numbing-and-Dissociation

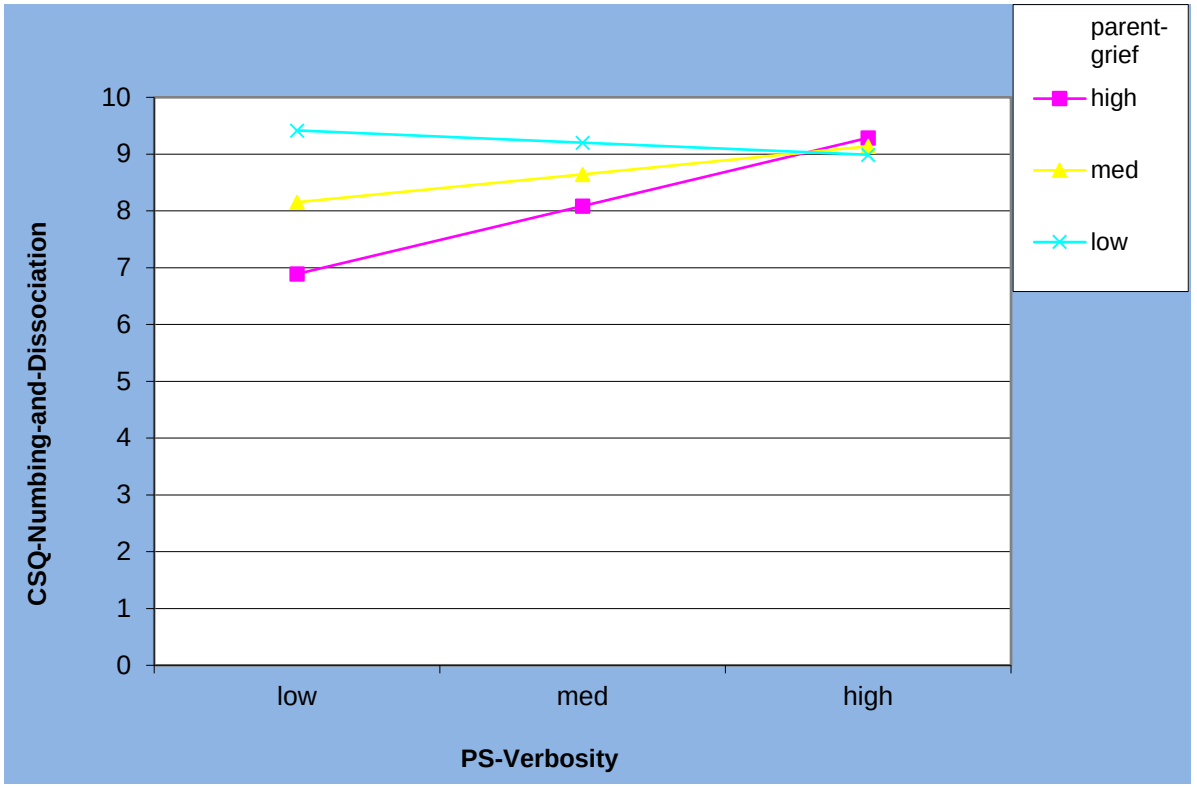


Figure 5.45 shows a moderation effect of parent-complicated-grief in the relationship between parent verbosity and child numbing and dissociation (CSQ-Numbing-and-Dissociation). PS-Verbosity was the independent variable (IV), while CSQ-Numbing-and-Dissociation was the dependent variable (DV). The ModGraph indicated that children whose parents had low verbosity presented higher numbing and dissociation when those parents also scored low in complicated grief, while differences in parental grief had no effect on child numbing and dissociation when parents had high verbosity.

Finally, hypothesis 10 was also tested in the non-bereaved sample. The results showed that parent-complicated-grief moderated the relationship between parenting style and behavioural problems among non-bereaved children as well.

Specifically, parent-complicated-grief moderated the impact of PS-overreactivity and PS-Verbosity on SDQ-Hyperactivity and SDQ-Peer-Problem.

In this chapter the aims, hypotheses, methodology and results of Study 3 were presented. The study recruited parents of children who had gone through the loss of a loved one and provided information on the following: their child's bereavement-related and general distress, their own attachment style and complicated grief, and their parenting style. A second sample of mothers whose children had not experienced bereavement also provided information on those variables. The questionnaires used were the Child Stress Questionnaire (CSDC; Saxe et al., 2003), the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), the Inventory of Complicated Grief (ICG; Prigerson et al., 1995), the Experience in Close Relationships Questionnaire-Revised (ECR; Fraley, Waller, & Brennan, 2000), and the Parenting Scale (PS; Arnold, 1993).

Ten hypotheses in total were tested. According to the findings, the bereaved children did not report more behavioural problems than the non-bereaved, while among the former, child behavioural problems and reaction to bereavement had significant positive correlations with parent attachment style, parent-complicated-grief and parenting style. Findings also suggested that the effects of bearevement on a child's distress was moderated by important parental charateristics: attachment style, complicated grief, and parenting style.

CHAPTER SIX
STUDY 3: DISCUSSION OF FINDINGS

This study investigates the behavioural differences between children with bereavement experience and children without such an experience. It also examines how the parental attachment dimensions, parents' unresolved complicated grief, and parenting style may contribute to behavioural problems in bereaved and non-bereaved children.

According to hypothesis 1, children with a bereavement experience were expected to report more behavioural problems than the non-bereaved children. The MANOVA analysis only showed significant differences in two scales: SDQ-Hyperactivity and SDQ-Peer-Problem Scales. According to hypotheses 2 and 3, among the bereaved children child behavioural problems were expected to have significant positive correlation with both of parent attachment dimensions, parent-complicated-grief, parenting style, duration of bereavement, and closeness with the deceased. These hypotheses were overall confirmed.

According to hypothesis 4, both parent attachment dimensions (anxiety, avoidance) were expected to moderate the link between bereavement status (bereaved, non-bereaved) and child-problems (SDQ). It was expected that bereaved children whose parents had relatively high attachment anxiety/avoidance would have more behaviour problems compared to those whose parents have low attachment anxiety/avoidance while the level of the behaviour problems among non-bereaved children would not be affected by the attachment anxiety/avoidance of their parents. The Hierarchical multiple linear regression analysis showed that both parent attachment dimensions moderated the relationship between bereavement status and behavioural problems in children. More specifically, ECR-Anxiety moderated the impact of bereavement

status on SDQ-Emotional-Problem, SDQ-Conduct-Problem, SDQ-Hyperactivity, SDQ-Peer-Problem, and SDQ-Total. Furthermore, ECR-Avoidance moderated the impact of bereavement status on SDQ-Hyperactivity.

According to hypothesis 5, parent-complicated-grief was expected to moderate the link between bereavement- status and child-problems (SDQ). It was expected that bereaved children whose parents had relatively high unresolved complicated grief would have more behaviour problems compared to those whose parents have low unresolved complicated grief while the level of the behaviour problems among non-bereaved children would not be affected by unresolved complicated grief by their parents. Results from the Hierarchical regression analysis did not confirm that hypothesis.

According to hypothesis 6, parenting-style was expected to moderate the link between bereavement-status and child-problems (SDQ). It was expected that bereaved children whose parents had relatively high laxness/overreactivity/verbosity would have more behaviour problems compared to those whose parents have low laxness/overreactivity/verbosity, while the level of the behaviour problems among non-bereaved children would not be affected by attachment laxness/overreactivity/verbosity in their parents. Hierarchical regression analysis showed that PS-Laxness and PS-Verbosity did not moderate that link while PS-Overreactivity moderated the relationship between bereavement-status and SDQ-Prosocial.

According to hypothesis 7, parental attachment avoidance and attachment anxiety would be the strongest predictors of child problems as measured by the SDQ and the CSQ. Among the bereaved group, Hierarchal regression analysis showed that ECR-Avoidance, ECR-Anxiety and parent-complicated-grief were the best predictors of overall child-problems (SDQ-Total) and ECR-Anxiety and PS-Overreactivity were the best predictors of overall child emotional reaction to

bereavement (CSQ-Total). Among the non-bereaved group ECR-Anxiety, parent-complicated-grief, and PS-Laxness were the strongest predictors of overall child-problems (SDQ-Total).

According to hypothesis 8, both parent attachment dimensions would moderate the link between parent-complicated-grief and child problems. It was expected that children, of the parents having unresolved complicated grief and had relatively high attachment anxiety/avoidance, would have more behaviour problems compared to those whose parents have low attachment anxiety/avoidance, while the level of the child behaviour problems of the parents having unresolved complicated grief would not be affected by attachment anxiety/avoidance in their parents. Hierarchical multiple linear regression showed that both parent attachment dimensions moderated the relationship between parent-complicated-grief and behavioural problems in children in the bereaved group but not in the non-bereaved group.

According to hypothesis 9, both parental attachment dimensions would moderate the link between parenting styles and child problems. It was expected that children, of the parents having laxness/overreactivity/verbosity and had relatively high attachment anxiety/avoidance, would have more behaviour problems compared to those whose parents have low attachment anxiety/avoidance, while the level of the child behaviour problems of the parents having laxness/overreactivity/verbosity would not be affected by attachment anxiety/avoidance in their parents. Hierarchical multiple linear regression analysis showed that parent attachment style moderated the relationship between parenting style and child behavioural problems in the bereaved group but not among the non-bereaved group.

According to hypothesis 10, parental-complicated-grief would moderate the link between parenting styles and child problems. It was expected that children, of

the parents having laxness/overreactivity/verbosity and had relatively high unresolved complicated grief, would have more behaviour problems compared to those whose parents have low unresolved complicated grief, while the level of the child behaviour problems of the parents having laxness/overreactivity/verbosity would not be affected by the unresolved complicated grief of their parents. Hierarchical multiple linear regression analysis showed that parental complicated grief moderated the relationship between parenting style and behavioural problems in children in both the bereaved and non-bereaved groups, but moderations in the former group were more extensive.

Discussion of Hypothesis 1

It was hypothesized that bereaved children would report more behavioural problems than non-bereaved children. The findings of the analysis showed strong significant differences in SDQ-Hyperactivity and SDQ-Peer-Problem subscales after parent variables (ECR-Avoidance, ECR-Anxiety, parent-complicated-grief, PS-Laxness, PS-Overreactivity, and PS-Verbosity) were controlled for. The bereaved sample demonstrated lower mean scores than the non-bereaved sample in both subscales.

In relation to hyperactivity, some research has focussed on the link between hyperactivity and the experience of bereavement in adolescents and children. In a longitudinal study, Birenbaum (2000) reported the reactions of bereaved adolescents and children after experiencing sibling loss from cancer at four different time points (before the death of sibling, two weeks following death, four months after, and 12 months after). The author used the Child Behaviour Checklist and found that different psychological symptoms including hyperactivity (impulsivity, arguing, and sadness) that were present before bereavement continued almost the same in the 12 months post-bereavement. Moreover, the bereaved adolescents and children reported higher scores in

hyperactivity when compared to children and adolescents without any experience of bereavement. These findings contradict the current study, according to which bereaved children reported lower hyperactivity when compared to non-bereaved children.

This contradiction may be explained by the fact that in the current study parental attachment anxiety and complicated grief were controlled for. Although there may be many parental qualities other than the controlled ones that can be linked to hyperactivity in children, these may be important parental factors influencing child behaviour. O'Connor, Heron, Golding, Beveridge, and Glover (2002) reported that higher maternal anxiety and depression during pregnancy are associated with ADHD in the offspring. Anxiety and depression are conditions related to attachment insecurity (Armsden, McCauley, Greenberg, Burke, & Mitchell, 1990; Kobak & Sceery, 1988).

Moreover, Li et al. (2010) also reported in a cohort study-based analysis in Denmark from 1987 to 2001 that the risk of hyperactivity disorder is higher in the children of parents with prenatal maternal bereavement – mothers who had experienced the death of someone close up to one year before or during pregnancy. Wolfelt (1996) noted that anxiety and depression due to loss, particularly the death of a closed and loved one, exacerbates hyperactivity in children. This author suggested that proper support, normal mourning, and counselling were necessary to lessen children's hyperactivity and noted that even medication does not work when hyperactive children are ignored in their grieving process.

Moreover, according to Wolfelt (1996), normal grief reactions are sometimes mistaken as hyperactivity/ADHD even by therapists, while children act out to express their stress and anxiety. Children are confused and depressed when they do not know and talk about death and grief (Charkow, 1998) and they become

isolated mourners (Smith & Pennells, 1995). Children improve emotionally when encouraged to open up about their feelings and develop their self-esteem (Seibert et al., 2003). Children of insecure mothers are unlikely to do that.

Moreover, the findings showed that the non-bereaved sample indicated higher mean scores in the SDQ-Peer-Problem scale than the bereaved group. The reason may be that bereaved children tried to deal with the stress by turning to their peers for support and re-establish good peer relationships to move on in life. Having good peer relationships is closely linked to high confidence and self-respect (Franco & Levitt, 1998) while poor peer relationships are linked to depression, anxiety, and social isolation (Hawker & Boulton, 2000). Close friendships have a strong impact on teenagers' lifestyle, adjustment, and coping stressful experiences (Schnaffner, 2005).

Although immediately after a bereavement experience they often report isolation and lack of interest in social relationships, the bereaved are encouraged and in a way forced by family and friends to get back into their social contacts and social network (Handsley, 2001). For example, good peer relationships in college students play a vital role in adjustment to experiences such as depression and anxiety and in making right choices in life, for example, use of alcohol (Schnaffner, 2005). Peer relationships are also important for the well-being and healing of children and adolescents.

Schultz (2007) reported that experience of bereavement works as a medium to develop good understanding, maturity, and satisfying relationships in adolescents. In his study, young women reported that they developed good peer relationships after the death of their mothers during adolescence. Martinson and Campos (1991) reported that only one-in-six bereaved adolescents showed a negative outcome when interviewed after 7–9 years of sibling loss due to cancer. Most of them had developed positive relationships.

Bereavement experience influences one's emotional relationships, and social interaction styles and frequencies (Martinson & Campos, 1991; Meshot & Leitner, 1993). Research shows that when adolescents go through the experience of depression and anxiety, they try to find good peer relationships to satisfy and support their emotions. Peer relationships are particularly important in children's lives when they are about to enter their adolescence (Field, Diego, & Sanders, 2001). In the Harvard Childhood Bereavement Study one–in-every-five children preferred to spend their time with peers after facing bereavement through parent death as compared to before (Worden, 1996).

Authors claim that adolescents are more relaxed in peers' company than being with adults Piaget (1969) and Worden (1996) reported that children experiencing bereavement are more comfortable in sharing their feelings with peers rather than parents. Peer relationships help in adjustment after the loss of a parent due to death (Garber, 1983) and teachers and parents report fewer behavioural problems of children who develop good peer relationships (Rowan, 1995).

Worden (1996) reports that bereaved children who showed good competence and adjustment to the bereavement experience had talked to their friends about their parent's loss. Peers and friends are considered to be good supporters in adjusting and moving on in life by 40% of adolescents and they feel less loneliness (Gray, 1989). Among all types of support friends are rated the most supporting figures in retrospective interviews to adults experiencing parent divorce or parent death (Marwit & Carusa, 1998). Bereaved children may attempt to develop good peer relationships and have fewer peer problems as one very good mechanism of dealing with their grief, gain social support, and reconnect with their social life.

Discussion of Hypothesis 2

It was hypothesized that among bereaved children, child behavioural problems

would show significant positive correlation with both parent attachment dimensions, parent-complicated-grief, parenting style, duration of bereavement, and closeness with the deceased. The results of this research supported this hypothesis. The behaviour problems in bereaved children, particularly emotional problems, conduct problems, hyperactivity, peer problems, and prosocial problems were positively correlated to both parent attachment dimensions, parent-complicated-grief, and parenting style. However, conduct problems in bereaved children did not correlate only to PS-Laxness and prosocial problems did not correlate to PS-Laxness and PS-Overreactivity. Additionally, only hyperactivity was positively correlated to duration of bereavement.

Several possible explanations can be given for positive correlation between child behavioural problems and the parent attachment dimensions. Previous studies have shown that insecure attachment is related to problems in bereavement (Field, 2006). Parents with avoidance attachment dimension show no emotional closeness to their children and think negatively about them (Rholes, Simpson, & Blakely, 1995; Rholes, Simpson, Blakely, Lanigan, & Allen, 1997). As a result, the children become more hostile and less close and may develop a negative view of their parents (Kerr & Stattin, 2000). This may be a reason they develop different behaviour problems.

On the other hand, parents with anxious attachment dimension are invasive and hindered in their attachment style (Collins et al., 2006) as they are more occupied with other intimate relationships and are fearful and worried of being abandoned (Shaver & Mikulincer, 2002) it is likely that children promote even more negative and disturbing behaviour.

Firstly, the findings show that child emotional problems are positively correlated to the both parent attachment dimensions. This is consistent with previous research that says that a parent with attachment anxiety more likely develops

emotional anxiety in the child and the child becomes reserved and withdrawn (Hudson, 2004). Moreover the parent with attachment avoidance develops emotional problems in the child that continue even in later life (Rapee, 2012).

Secondly, the findings show that child conduct problems are positively correlated to the parent attachment dimensions. The research explains these findings as the insecure attachment pattern often develops different conduct problems in children and adolescents (Hill, Fonagy, & Safier, 2003).

Thirdly, the findings show that child hyperactivity is positively correlated to the parent attachment dimensions. The research says that disturbed early parent-child attachment relationships greatly affect children with ADHD in their impairment in self-regulation (Sandberg, 1996).

Fourthly, the findings suggest that child peer problems are positively correlated to the parent attachment dimensions. This is consistent with the previous studies that say that the child's early attachment relationship with the parent or primary caregiver creates that child's internal working model for their future peer relationships and other adult relationships (Sroufe & Fleeson, 1986).

Finally, the findings of the current study suggest that child prosocial problems are positively correlated to the parent attachment dimensions. The research has proven that insecure attachment develop antisocial and rebellious behaviour problems in the children (Bretherton, Golby, & Cho, 1997)

Moreover, the findings of current study show that child behaviour problems are positively correlated to parenting styles. Previous research supports these findings and says poor and abusing parenting causes low emotional support in adolescents (Miller, Smyth, & Mudar, 1999). Research further explains that when parents are emotionally responsive, the children can cope easily with stressful emotions (Sroufe, Carlson, Levy, & Egeland, 1999), however when parents are

less supportive and emotionally less responsive, the children are more at risk of depression (Dozier, Stovall, & Albus, 1999). Emotional regulation in children is influenced by the way parents deal with their own emotions (Fonagy, Gergely, Jurist, & Target, 2002; Main & Goldwyn, 1984).

Moreover, many aspects of parenting play roles in the socialization of children. Parents who are strict and harsh towards their children develop violence and aggression in the child's behaviour (Bandura & Walters, 1959). Further, according to observational studies of preschoolers' behaviour, even either very strict or very lax mothers' children develop poor or violent behaviour (Baumrind, 1968; Baumrind & Black, 1967). Baumrind reported that lax parents have less controlling strategies towards children. Lax parents are highly accommodating (McCord et al., 1961). By giving in, they may try to apply a short-term solution to calm down the children and ignore and even allow and teach them to continue misbehaving. Overreactive parents are controlling and authoritative (Baumrind, 1968). They may apply disciplinary strategies to control their children, including corporal punishments, rebuking, threats that lead to aggression, anger, and insulting behaviour in children.

Parents with verbosity factor in their parenting style may unintentionally fortify with long lectures and scolding that cause continue misbehaviour and carelessness. According to Hakman and Sullivan (2009), higher verbosity in mothers is closely associated to higher child noncompliance rates. In concludion, different parenting styles may be associated with different child behaviour problems as parenting correlates to child behaviour problems.

The findings show positive correlation between a parent's complicated grief and child behaviour problems, and the research gives evidence that grief reactions are intergenerationally transmitted (Gajdos, 2002). Children have depressive disorder and coping problems when their parents are grieving (Beardslee,

Gladstone, & O'Connor, 2011; Weissman et al., 2006). The shifts and twists in the parents' mood are surprising for the children and sometimes they blame themselves for the whole situation (Beardslee et al., 1997). Particularly, death of a child changes the parent–child relationship (Bank & Kahn, 1982) as a parent's grief patterns significantly affect the surviving, grieving child (Bank & Kahn, 1982) and parents may not be available to support the surviving child just when the child need more support (Davies, 1995). The research says that sometimes the surviving children try to support their parents and hide their own grief and make themselves more depressed (Balk, 1983). When the primary caretaker can manage personal stress, calm the infant, communicate through emotion, share joy, and forgive easily, the young child's nervous system becomes "securely attached." Our attachment bonds shape our abilities to deal with stress and balance emotions (Segal & Jaffe, 2012).

Furthermore, studies suggest that maternal grief and anxiety were significantly related to child problems (Martin, Hiscock, Hardy, Davey, & Wake, 2007).

Discussion of Hypothesis 3

It was hypothesized that among the bereaved group children's reaction to bereavement was expected to have a significant positive correlation with both parental attachment dimensions, parent-complicated-grief, parenting style, duration of bereavement, and closeness with the deceased. The findings of the analyses showed that five of the CSQ subscales correlated positively with parental variables or aspects of the bereavement while CSQ-Impairment-in-Function did not correlate with any.

In particular, the CSQ-Immediate-Response subscale showed a positive significant correlation with closeness to the deceased and significant negative correlation with PS-Laxness. On the other hand, the CSQ-Reexperiencing subscale showed no significant correlation with any variable except with parental

complicated grief. Moreover, CSQ-Avoidance showed no significant correlation with any parental variable, but it showed significant negative correlation with duration of bereavement. The CSQ-Numbing and Dissociation scales indicated a significant positive correlation with ECR-Anxiety and duration of bereavement but no significant correlation with other variables. CSQ-Increased Arousal showed significant positive correlation only with ECR-Anxiety and no significant correlation with other variables. Finally, the CSQ-Impairment-in-Function scale showed no significant correlation to any of the parental variables, duration of bereavement, or closeness to the deceased.

In the current study findings firstly, child immediate response showed negative correlation to parental laxness. Previous studies report mixed outcomes for children of lax parents. On the one hand, Baumrind (1968) reported that lax parents are often too lenient and accommodating. They tend to show too soft an attitude towards their children and give in to whatever they demand. In some cases they may compensate for what they lacked as a child (Rosenthal, 2014). Baumrind (1991) and Slicker (1998) reported that these parents normally try to provide a temporary solution to the problem of their children, which however leads to long-term negative behaviours in children, for example, impulsiveness, even drug addiction.

According to some studies, children with lax parents find it difficult to learn to overcome problem behaviours and are careless in many situations (Santrock, 2007). On the other hand, some research has shown that in some instances children of lax parents become relatively emotionally secure, mature, and independent and learn to face challenges. For example, in a recent study teenagers whose parents scored higher laxness were the least involved in heavy alcohol drinking (Verzello, 2014). It may be the case that lax parenting allows bereaved children to grieve, by not putting a lot of pressure on them and giving them more time to return to normal routine. That may have been reflected in

lower scores on the children's immediate response to the stress of bereavement.

Moreover, the CSQ-Immediate-Response subscale also showed a positive significant correlation with closeness to the deceased. Research has shown that the individuals who report closeness to the deceased are greatly affected by the death as compared to others who are less closed (Reed & Greenwald, 1991). The death of a close one brings many change in the emotional and social life of a child and the greater the closeness, the more significant the changes. Moreover, close relationships suggest the presence of attachment and loss of an attachment relationship has a great impact on children's sense of emotional security (Carlson, Sroufe, & Egeland, 2004).

Secondly, the findings show that child reexperiencing is correlated to parental complicated grief. The present findings are consistent with previous research suggesting that child stress problems are associated with maternal emotional distress (Goodman, 2007; Lovejoy, Graczyk, O'Hare, & Neuman, 2000). When a surviving parent manages their own mourning and grieving process and finds difficulty in watching their grieving child, they deny their own grieving and do not recognize the child' grief. They become less responsive because of their own grief and the child develops overprotectiveness towards the parent and other survivors out of their own fear of loss (Goldman, 1996).

When parents are overwhelmed or upset they cannot help and support the child in coping during the grieving process. If a parent has been unable to emotionally overcome a loss it is likely that their child will also be unable to do so and keep reexperiencing the event. Thirdly, the findings indicate that the child's grief avoidance is negatively correlated with the duration of bereavement. Like adults, children also apply avoidant strategies to avoid pain and stress – not thinking or talking about the event, ignoring or staying away from the painful reality or memories of the deceased. Although this happens more intensely early in the

bereavement process, it decreases with time as the bereaved realize the loss and allow themselves to experience it.

Fourthly, the findings show that child's numbing and dissociation had a positive correlation with parental attachment anxiety. Studies have shown that insecure attachment is related to problems in bereavement (Field, 2006). Parents with relatively high attachment anxiety are invasive and hindered in their emotional communication (Collins et al., 2006). As they are more occupied with other intimate relationships and worried about being abandoned (Shaver & Mikulincer, 2002), it is likely that they give less emotional support to their distressed and bereaved children. Such lack of parental support maintains negative and disturbing behaviour. Moreover, Hirshfeld et al. (1997) report that anxious mothers tend to criticise their children more than mothers low in attachment anxiety and criticism may be the reason that a bereaved child becomes more withdrawn and anxious. Numbing and dissociation is a usual response to trauma, associated with impairment in functioning, mental health problems, aggression, and negative behaviour (Armstrong et al,. 1997).

Finally the findings show that child's increased arousal also showed positive correlation with parental attachment anxiety. Previous research seems consistent with these findings, as anxiously attached parents are unable to provide consistent care and therefore would be unlikely to properly sooth a child that has been distressed by bereavement. Such children would be expected to show greater hyperarousal.

Discussion of Hypothesis 4

It was hypothesized that the two parental attachment dimensions (anxiety and avoidance) would moderate the link between bereavement status (bereaved, non-bereaved) and child-problems (SDQ). It was expected that bereaved children whose parents had relatively high attachment anxiety/avoidance would have

more emotional and behavioural problems compared to those whose parents had low attachment anxiety/avoidance, while the level of the behaviour problems among non-bereaved children would not be affected by the attachment anxiety/avoidance of their parents.

The findings showed that bereaved children presented more behavioural problems than the non-bereaved when their parents scored high in attachment anxiety or avoidance, while such differences between the two groups did not exist when parental attachment was not taken into consideration. In particular, the bereaved children presented higher scores than the non-bereaved in five subscales (emotional problems, conduct problems, hyperactivity, and peer problems) as well as the overall SDQ score when their parents had high attachment anxiety and higher scores in the hyperactivity subscale when parents showed high attachment avoidance.

No known research so far has investigated the link between parental anxiety and child behaviour problems among bereaved children. However, other relevant findings of attachment theory are consistent with the present findings.

Firstly, the findings showed that bereaved children presented more emotional problems when their parents had high attachment anxiety, while such differentiation did not occur among non-bereaved children. Previous studies support the association between parental attachment anxiety and problems in emotional regulation in childhood and adolescence. An insecurely attached parent tends to be less responsive to the needs of the child, negatively affecting parent-child attachment regulation, setting off an insecure parent–child bond, which will then lead to emotional problems and peer problems in the children and adolescents (Bosquet & Egeland, 2006). Attachment research provides ample evidence to explain why individuals higher in attachment anxiety may face parenting problems. Mikulincer & Shaver (2007) reported that individuals with

higher attachment anxiety live with fear of rejection and abandonment, desire to get closeness to others, and are vulnerable to depression when their partners are less responsive. Anxiously attached individuals show higher and more exaggerated responses to stressors (Maunder, Lancee, Nolan, Hunter, & Tannenbaum, 2006). Individuals with such emotional instability are likely to find parenting challenging, particularly when they have to support bereaved and distressed children.

Secondly, the present findings showed that bereaved children present more conduct problems when their parents scored high attachment anxiety, while parental anxiety has no similar effects on child problems in the non-bereaved group. Previous studies report that child conduct problems are based on different factors, among which family relationships and parent–child attachment are of primary importance (Aguilar, Sroufe, Egeland, & Carlson, 2000; Brennan, Hall, Bor, Najman, & Williams, 2003). Anxiously attached parents are likely to ignore or emotionally neglect their children, experiences that often lead to aggression and defiance. Moreover, research shows that depression in the mother, which is closely associated with attachment anxiety, negatively affects the child's conduct and adjustment to the parent-child interaction (Downey & Coyne, 1990).

Thirdly, the bereaved children showed higher hyperactivity when their parents scored high in attachment anxiety, while no such an effect was observed among the non-bereaved. This finding is consistent with previous research. Studies show that hyperactivity problems in children are associated with quality of parenting and the parent–child caregiving relationship (Barkley, 1998).

Fourthly, compared to the non-bereaved, the bereaved children showed more peer problems when their parents scored relatively high in attachment anxiety. Previous research shows that bereavement experience affects one's emotional

and social contact while conducting social relationships (Martinson & Campos, 1991; Meshot & Leitner, 1993). Some studies indicate that the intensity of loss is associated with negative social interactions and that experiencing loss in interpersonal relationships is associated with loneliness (Hammen, 1978). However, present findings suggested bereaved children had better peer relationships (see above). Perhaps parental attachment anxiety determines the degree of peer problems among bereaved children. A bereaved child with a parent scoring high in attachment anxiety is less likely to be competent in peer relationships because in the child's first experience of relationships, the relationship to the parent is less positive.

Lastly, parental attachment avoidance moderated only one association. Bereaved children showed more hyperactivity when their parents scored high in attachment avoidance, while a similar effect was not detected among the non-bereaved. Previous research supports these findings as parents with high attachment avoidance are likely not to be appropriately responsive to the needs of their children. Avoidant attached individuals tend to be aggressive and unreliable (Collins & Read, 1990) and are distrustful and unwilling to accept support when they are in distress (Collins & Feeney, 2000; Simpson, Rholes, & Nelligan, 1992). Studies report that avoidant parents show less emotional closeness to their children. Rholes, Simpson, and Blakely (1995) and Rholes, Simpson, Blakely, Lanigan, and Allen (1997) in their studies on parents with and without children found that parental attachment avoidance and attachment anxiety are closely linked to poorer parenting, negative and less warm relationships to their children, and more controlling and cold parenting style. In addition, parental attachment avoidance is associated with less desire to go through the experience of parenting and to experience parenthood satisfaction. Studies report that as a result, their children become more emotionally detached, suppressing the need for parental responsiveness and care (Mikulincer & Shaver, 2007).

The present findings showed that attachment anxiety is the attachment dimension more extensively involved in the link between bereavement status and child emotional and behavioural problems. Several studies suggest that the children's reaction to stress is greatly affected by their parent- child attachment relationship. A study on young school-aged children shows that children present different behavioural reactions when they are separated from their mothers due to the latter's imprisonment. These reactions are aggression, sadness, humiliation, loneliness, and fear (Hale, 1988; Hungerford, 1993; Thompson & Harm, 1995). In some studies parents of the bereaved children have reported higher emotional problems in children than non-bereaved children's parents, even up to two years after bereavement (Black, 1985).

Discussion of Hypothesis 5

It was hypothesized that parental complicated grief would moderate the link between bereavement-status and child-problems (SDQ). It was expected that bereaved children whose parents had relatively higher unresolved and complicated grief would have more behaviour problems compared to those whose parents had lower unresolved complicated grief, while the level of behaviour problems among non-bereaved children would not be affected by parental complicated grief. The findings showed that parental complicated grief did not moderate the relationship between bereavement status and any of the child problem subscales.

These findings were somewhat surprising as previous literature seemed to suggest such a link. Previous studies show that there is a correlation between behaviour problems in bereaved children and parents' communication about death in the bereavement support parents provide to their children (Martinson & Campos, 1991; Gibbons, 1992). When parents communicate effectively about death with their bereaved children, they also seem to provide better support, and therefore children show fewer behavioural problems. It was hypothesized

that parental complicated grief would have a greater impact among the bereaved children but this was not confirmed.

Discussion of Hypothesis 6

It was hypothesized that parenting styles (PS-Laxness, PS-Verbosity, and PS-Overreactivity) would moderate the link between bereavement-status and child-problems (SDQ). It was expected that bereaved children whose parents presented a relatively higher laxness/overreactivity/verbosity style would have more behavioural problems compared to those whose parents had a lower laxness/overreactivity/verbosity style, while the level of behaviour problems among non-bereaved children would not be affected by such differences in parenting style.

The findings showed that only the parenting style subscale PS-Overreactivity moderated the relation between bereavement-status and the child behaviour subscale SDQ-Prosocial.

Research shows that parenting styles are different emotional and communicative approaches of parents towards their children (Darling & Steinberg, 1993). Several studies show that overreactivity is a strict and controlling parenting style. Arnold et al. (1993) reported in their research on elementary school-aged children that laxness is permissive parenting but overreactivity is strict parenting. Moreover, the research shows that both the authoritarian and the permissive parenting styles have caused negative behaviour in children (Baumrind, 1991; Slicker, 1998) while authoritative parenting leads to positive and balanced child behaviour (Slicker, 1998; Bronte-Tinkew et al., 2006).

Some studies indicate that overreactive parenting style is associated with behaviour problems, such as more controlling parents use physical discipline that develops externalizing problems in children (Gershoff, 2002). Consequently,

these children try to restrict their disturbing behaviour and direct their focus on the outcome of their behaviour being empathetic, kind, and more prosocial (Hoffman, 2000).

The findings showed that parenting overreactivity reported lower support and warmth for the children. This may be the reason that bereaved children showed more prosocial scores. They may seek refuge in society to make good social relationships to avoid negative parenting. Research says that bereaved children particularly the bereaved siblings behave positively, maturely and adapt prosocial behaviour and become more kind, tolerant, and sympathetic towards others (Hogan & DeSantis, 1996; Hogan & Greenfield, 1991).

Discussion of Hypothesis 7

It was hypothesized that both parent attachment dimensions, parent-complicated-grief, and parenting styles would be the best predictors in bereaved children's problems (SDQ and CSQ). It was expected that parent subscales (attachment avoidance, attachment anxiety, and parent-complicated-grief, parenting laxness, parenting overreactivity, and parenting verbosity) would be the best predictors of child problems among the bereaved children.The findings showed that ECR-Avoidance and ECR-Anxiety were more prevalent predictors of child psychological problems among the bereaved but not the non-bereaved. Perhaps the stress of bereavement increased the importance of parental attachment compared to other predictors of child problems (e.g. parenting style).

Discussion of Hypothesis 8

It was hypothesized that both parent attachment dimensions would moderate the link between parent-complicated-grief and child-problems (SDQ and CSQ). It was expected that children of parents with relatively higher attachment anxiety/avoidance would have more behaviour problems due to their parents'

complicated grief compared to those whose parents have lower attachment anxiety/avoidance. The findings showed that both parent attachment dimensions moderated the relationship between parent-complicated-grief and behavioural problems in children, but only in the bereaved group. Particularly, ECR-Anxiety moderated the impact of parent-complicated-grief on SDQ-Emotional-Problem, CSQ-Immediate-Response, CSQ-Reexperiencing, CSQ-Avoidance, CSQ-Numbing-and-Dissociation, and CSQ-Increased-Arousal while marginally significant to CSQ-Impairment-in-Function. Additionally, ECR-Avoidance moderated the impact of parent-complicated-grief on SDQ-Emotional-Problem, CSQ-Immediate-Response, CSQ-Numbing-and-Dissociation, and CSQ-Increased-Arousal.

No research known to this researcher so far has tested this hypothesis. Cicchetti and Lynch (1995) in their research on parents who were neglected in their childhood found that they were more likely to neglect their own children, resulting in a perpetuating cycle of behaviour problems and depression. On the other hand, research indicates that unresolved parental grief related to the death of a close one is associated with a disorganized insecure attachment style in children (Ijzendoorn, 1995). When such parents experience memories of the deceased, they exhibit frightening behaviour towards their children. These parents therefore become alarming rather than a safe haven. As a result, their children become confused and caught up between their feelings of fear and their need for attachment and develop a disorganised attachment style (Main & Hesse, 1990; Main & Morgan, 1996). Main and Hesse (1990) proposed that unresolved grief in parents is associated with disorganized attachment style and emotional problems in both adults and children.

Anxiously attached parents who suffer from complicated grief are more likely to have children with problems as they are more likely to neglect or be harsh with them because of the grief. Previous studies showed that individuals with complicated grief in the bereavement process are more preoccupied with the

thoughts of the deceased and experience feelings of guilt, bitterness, and anger towards death and develop estrangement, loneliness, and avoidance (Horowitz, Siegel, Holen, & Bonanno, 1997; Prigerson, Monk, Reynolds, & Bierhals, 1995). It may be the case that anxiously attached parents with complicated grief are more consumed in memories of the deceased and show less interest in other relationships including their bereaved children. As bereavement is a major stressor, parental protective capacity is challenged. On the other hand, attachment avoidance in some cases seemed protective among parents with low complicated grief.

Discussion of Hypothesis 9

It was hypothesized that both parent attachment dimensions would moderate the link between parenting styles and child problems. It was expected that children of parents high in laxness/overreactivity/verbosity who also had relatively high attachment anxiety/avoidance would have more behavioural problems compared to those whose parents would have low attachment anxiety/avoidance. The findings showed that both parental attachment dimensions moderated the relationship between parenting styles and behavioural problems in children but only in the bereaved sample, that is only in conditions of a stressful experience of loss.

Firstly, the findings indicate that parental attachment anxiety moderated the impact of parental laxness on child's emotional problems, prosocial behaviour, and peer problems. Several explanations can be given from previous studies. Research has confirmed that early parent–child attachment relationships are linked with adult attachment patterns (Schneider, Gruman, & Coutts, 2005). Moreover, Bartholomew (1990) proposed that anxious adults are worried about being abandoned in their relationships and this may relate to the fact that parents with attachment anxiety tend to show laxness in their parenting style and allow their children to do too much. Study on parenting styles states that lax

parents are less demanding, more permissive, and have less control of their children and so those children are not well-regulated emotionally, not very mature, nor responsible (Arnett, 2010). According to Berger (2005), such children sometimes appear to have good social manners but often they are just trying meeting their needs. This may be behind their problems in developing good peer relationships.

Another study suggests that ineffective parenting style including lax parenting is linked with antisocial behaviour and substance abuse in children and adolescents (Patterson, Reid, & Dishion, 1992). They suggest that poor supervision is linked with parent–child arguments and poor relationships. Research also suggests that children of anxiously attached parents tend to be insecure, confused, and distrustful (Aronson, Wilson, & Akert, 2011) and they sometimes adopt avoidant strategies during stress to protect themselves against their unpredictable parents.

Secondly, the findings indicated that parental attachment anxiety moderated the impact of parenting overreactivity on child impairment in function, numbing and dissociation, and prosocial behaviour. Overreactive parents are very strict and little supportive to their children, so those children often develop a variety of emotional and behavioural problems, including little social flexibility, low self-esteem, high anxiety, and depression (Berger, 2005; Arnett, 2010) .Thirdly, the findings indicated that parental anxiety moderated the impact of parenting verbosity on a child's emotional difficulties. Parents with high verbosity tend to be abusive and authoritarian, less responsive, and more controlling. If they are also anxiously attached those problems increase.

The findings also show that parental attachment avoidance moderated the impact of parenting laxness and overreactivity on child's emotional and behavioural difficulties. Research indicates that individuals with avoidant

attachment style hardly trust others, tend to avoid close relationships, are less caring, less cooperative, and adapt oppressive and abusive behaviour in their social interactions (Mikulincer & Shaver, 2007; Schneider, Gruman, & Coutts, 2005). This distant behaviour is linked with an unsupportive parenting style as they show low responsiveness to their children. Avoidant parents are less responsive especially when the child is distressed (Edelstein et al., 2004) and tend to adopt a more controlling and overreactive strategy in their parenting (Mikulincer & Shaver, 2007). As a result their children are low in communication, confidence, and social adaptability (Berger, 2005; Arnett, 2010). Nonetheless, the findings also indicated that parental attachment avoidance can have some protective effects on the children when parents are also low in verbosity.

Discussion of Hypothesis 10

It was hypothesized that parental complicated grief would moderate the link between parenting styles and child problems. It was expected that children, of the parents having laxness/overreactivity/verbosity and had relatively high unresolved complicated grief, would have more behaviour problems compared to those whose parents have low unresolved complicated grief, while the level of the child behaviour problems of the parents having laxness/overreactivity/verbosity would not be affected by unresolved complicated grief by their parents.

The findings showed that parental complicated grief moderated the relationship between parenting style and behavioural problems in children in both the bereaved and the non-bereaved samples. Specifically, in the bereaved sample, parental complicated grief moderated the impact of PS-Laxness on CSQ-Numbing-Dissociation and CSQ-Impairment-in-Function while on CSQ-Avoidance marginally significant. Additionally, it moderated the link between PS-Overreactivity and child SDQ-Hyperactivity, SDQ-Prosocial, and CSQ-Immediate-Response; moreover, parent-complicated-grief moderated an impact of PS-

Verbosity on SDQ-Prosocial, CSQ-Numbing-and-Dissociation, and CSQ-Impairment-in-Function while marginally significant to CSQ-Immediate-Response and CSQ-Avoidance. In the non-bereaved sample moderating effects were less extensive: parental complicated grief moderated the impact of PS-overreactivity and PS-Verbosity on SDQ-Hyperactivity and SDQ-Peer-Problem, respectively.

These findings are consistent with previous research as bereaved parents are greater victims of unresolved grief and psychological problems (Li et al., 2005). Insecure attachment style and grief avoidance are some of the factors involved in parents' unresolved grief (Meert et al., 2010) and they are consistent with Bowlby's attachment theory that says that unresolved grief can be the result of grief avoidance (Bowlby, 1980). Parents' attachment styles and parenting styles are associated with each other, as confirmed in hypothesis 9. As bereavement is a major stressor, they appeared more relevant in the bereaved sample.

Firstly, parental complicated grief moderated the impact of parenting laxness on child's numbing and dissociation, impairment in function and avoidance. Specifically, lower laxness and higher complicated grief were linked with lower child numbing and dissociation and lower impairment in function. It maybe that low laxness and high grief in the parent make the parent more responsive to the bereavement needs of the child. Secondly, parental complicated grief moderated the impact of parenting overreactivity and child's hyperactivity, prosocial behaviour, and immediate response. Research suggests that mothers of hyperactive children scored higher on overreactivity Seipp & Johnston, 2005) while, as stated previously, parental overreactivity develops social and emotional regulation problems in children.

Finally, research indicates that poor communication and excessive verbosity may develop child behaviour problems (Patterson, 1982; Scaramella & Leve, 2004) and that verbosity is higher when stress is higher in families (Hakman & Sullivan,

2009). On the other hand, in the bereaved sample, lower parental verbosity together with higher parental complicated grief was linked to lower numbing in children. It may be the case that lower verbosity and higher grief in the parent may lead to a better parental response to the bereaved child's needs.

Limitations of Study 3

Study 3 has several limitations. Firstly, parental reports were the sole source to obtain data on child behaviour and distress problems. Although ideally they could be among the best sources of information about child behaviour, these reports may be influenced by parents' own perceptions and situation. According to Kroes and colleagues, "Despite the problems of sampling and criterion validity, there is growing evidence that parental distress or psychopathology … may cause small to moderate parental reporting distortions" (Kroes, Veerman, & Bruyn, 2003, p.196). However, the particular scales used were well-validated and very widely used.

It was originally planned to include children as participants in this study as research suggests that child reports may be more predictive of child behaviour than parental reports (Haines, Neumark-Sztainer, Hannan, Robinson-O'Brien, & Pediatr, 2008). However, I needed to follow the recommendation of the departmental ethics committee suggesting that children may be at some psychological risk due to their vulnerability to bereavement.

In this chapter the findings of Study 3 were discussed. Findings were consistent with the relevant literature suggesting that parental attachment and bereavement experiences have an impact on their children's bereavement distress. The findings suggested that it was such parental characteristcs rather than the experience of bereavement per se that determined the level of distress that bereaved children experienced.

CHAPTER SEVEN
GENERAL DISCUSSION AND CONCLUSIONS

The findings of Study 1 explored two research questions – what are the main themes in retrospective accounts of childhood bereavement and how do those themes relate to current attachment style in adulthood. Thematic analysis indicated a number of themes of childhood bereavement experience and these seem to be associated with current adult attachment style.

In particular, seven themes related to emotions, feelings, and descriptions of the self at the time of loss. The themes *Self is suppressing feelings, Self has somatic reactions*, *Self has psychological difficulties,* and *Self feels positive* were predominantly shown by the individuals with dismissing attachment style. Moreover, the themes *Self is seeking contact with deceased* and *Self cannot understand death* were themes more strongly presented by individuals with preoccupied and fearful attachment styles, while the theme *Self is consumed* was more specific to individuals with a preoccupied style.

In addition, three themes related to accounts providing current descriptions of the self. The theme *Self wishes closeness* was more prevalent in the narratives of dismissing and preoccupied individuals, the narrative *Self is in peace was predominant* in secure narratives and the theme *Self is still affected* was more prevalent in the accounts of fearful and preoccupied and to a lesser extent dismissing individuals.

Moreover, five themes provided accounts describing the deceased and those too seemed to be linked with different attachment styles. The theme *the deceased was supportive/emotionally close* was stronger among individuals with a fearful attachment style and to a lesser extent by those with a dismissing style while the themes *the deceased had positive social attributes, the deceased had leadership qualities* and *the deceased was competent* were more predominant in the

narratives of preoccupied individuals. Finally, the theme *the deceased was vulnerable* was stronger in the accounts of fearful and dismissing individuals.

The findings of Study 1 indicated that university students with different attachment styles tended to generate different types of narrative about their childhood bereavement experience and extended previous attachment research that utilised retrospective accounts. Finley and Payne (2010) in their retrospective study recorded a number of group meetings with bereaved carers in various relationships with the deceased person and found that sadness, loss and loneliness were major themes in their accounts.

Moreover, in a recent study by Beverung and Jacobvitz (2014), the authors interviewed 60 women using the Adult Attachment Interview (George, Kaplan, & Main, 1985) in order to examine their childhood attachment relationship to parents and experience and response to bereavement. The authors found that secure women reported less unresolved grief, being in agreement with the current study. As the Adult Attachment Interview focusses more on narrative coherence rather than content, while the current analysis was only based on content, the present findings provide additional support for the link between current attachment security and childhood loss.

The findings of Study 1 indicated that adult attachment style is linked with how individuals understand childhood bereavement experience at present. The accounts they provided show how they understand what happened now regardless of whether they themselves make distinctions between now and then. As they say what they say now, their accounts reflect their current state of mind in relation to the past bereavement.

In agreement with previous research (Meier, Carr, Currier, & Neimeyer, 2013; Stroebe, 2002), the main assumption behind Study 1 was that adults with different attachment experience have different experience of bereavement.

However, Study 1 did not explicitly look for any links between adult complicated grief, adult attachment style, and childhood experience. The aim of Study 2 was exactly to clarify those links. According to the findings of Study 2, adults who experienced the loss of a caregiver in childhood, were unable to resolve their grief if they had relatively poor bonding with their parents as children and experienced separation anxiety. The findings also showed that poor parental bonding (poor care and high overprotection) lead to unresolved grief in childhood only when the individuals had developed attachment anxiety as adults.

This latter finding is of particular importance as it suggests that negative caregiving experience in childhood does not automatically lead to unresolved grief, but it requires the presence of a particular attachment style in adulthood, attachment anxiety, to do so. In other words, according to the present findings, even if poor parental bonding leads directly to unresolved loss in childhood or indirectly through separation and attachment anxiety in childhood, these links do not automatically continue to exist in adulthood. This suggests that factors other than parental caregiving may play a critical role for the experience of childhood grief among adults. If such factors sustain an anxious attachment style in childhood into adulthood, or transform a different attachment style in childhood into anxious attachment in adulthood.

Study 1 suggested that adults who had been bereaved as children present different accounts of their bereavement experience according to their adult attachment style. On the other hand, Study 2 suggested that adults who had lost a caregiver in childhood reported complicated grief in adulthood depending on their parental bonding, separation anxiety, and adult attachment style; it also suggested that quality of bonding with parents in childhood lead to unresolved grief in adulthood only when such bonding had led to an anxious attachment style in adulthood.

Study 3 examined a further hypothesis – that complicated grief would be intergenerationally transmitted based on relevant parental characteristics – parental attachment style, parenting style, and parental complicated grief. Study 3 was about how adults' current state of mind in relation to bereavement (e.g. complicated grief) and in relation to attachment (their attachment style) had an effect on how their children respond to their own experience of bereavement.

The findings of Study 3 did not support the hypothesis that children with bereavement experience reported more behavioural problems than the children without any experience of bereavement. On the contrary, they suggested that bereaved children were better off than non-bereaved in terms of hyperactivity and peer problems. However, the findings of Study 3 did support the hypothesis that among bereaved children, child behavioural problems and specific reaction to bereavement were positively correlated with many parental variables (both parent attachment dimensions, parent-complicated-grief, parenting style) as well as duration of bereavement and closeness with the deceased.

Findings also showed that both parental attachment dimensions (anxiety, avoidance) moderated the link between bereavement status and child behavioural problems so that bereaved children whose parents had relatively high attachment anxiety or/and had more behavioural problems compared to those whose parents had low attachment anxiety or/and avoidance while the level of the behaviour problems among non-bereaved children was not affected by parental attachment style.

The findings of Study 3 also suggested that parenting style, particularly laxness, verbosity, and overreactivity moderated the link between bereavement status and child behavioural problems so that bereaved children whose parents had relatively high scores on those styles had more problems compared to those whose parents had low scores, while the level of problems among the non-

bereaved was not affected by parenting style. Complicated grief was found to have no moderating effects on the link between parenting styles and child behavioural problems.

Moreover, the findings of Study 3 suggested that in the bereaved sample both parental attachment dimensions moderated the link between parental complicated grief and child problems so that children whose parents had unresolved grief and also had relatively higher attachment anxiety or/and avoidance had more behavioural problems compared to those whose parents had also high unresolved grief but low attachment anxiety or/and avoidance. On the other hand, in the non-bereaved sample neither of the parental attachment dimensions moderated that link. Moreover, the findings of Study 3 also suggested that both parental attachment dimensions moderated the link between parenting styles and child problems but only in the bereaved group. In the non-bereaved group such moderating effects were not found.

The findings of Study 3 also supported the hypothesis that parental complicated grief moderated the link between parenting styles and child problems in both the bereaved and the non-bereaved groups. Finally, in the bereaved group parental attachment avoidance, parental attachment anxiety, and parental complicated grief were the best predictors of child problems, while among the non-bereaved parental attachment anxiety, parent-complicated-grief, and parental laxness had that capacity.

The findings of these three studies taken together provide some insight into how adult patterns of response towards bereavement may be related to childhood experience and seem to be linked with three main issues discussed in the attachment literature. The first main issue relates to whether adverse experience necessarily leads to poor adult outcomes, in this case unresolved grief, and the second to whether childhood attachment styles remain stable over time all the

way into adulthood. The third issue relates to the extent to which, like attachment styles, patterns of response to bereavement are intergenerationally transmitted.

In Study 2, the means of the scales indicating quality of parental attachment suggests only moderate issues among children who lost at least one parent, while the correlations between unresolved grief and indicators of relatively poor parent–child bonding are rather weak. Also, findings in Study 3 suggest that bereaved children did not have more behavioural problems than the non-bereaved when the overall samples were compared. These findings are in agreement with researchers observing that very negative events during one's childhood do not always lead to negative outcomes, either in childhood or adulthood (Zolkoski & Bullock, 2012). These authors claim that not all children who experience abuse, neglect, or loss of parent are affected in the same way and some appear to adjust reasonably well.

Attachment researchers have emphasized the importance of a secure attachment relationship and the development of the capacity for understanding mental states in self and other in protecting children from adverse aspects of the psychosocial environment and negative events (Carnes & Crenshaw, 2015; Mikulincer & Shaver, 2014). This also applies to copying with bereavement, as a number of studies have emphasized. Authors have argued that understanding quality of attachment is critical in understanding the mechanisms of copying with bereavement (Stroebe, Schut, & Stroebe, 2005), while others have highlighted the impact of attachment style on how the lost person will continue to be remembered and their role in one's life evaluated (Field, Gao, & Paderna, 2005).

In agreement with previous research observations, the present findings suggest that loss of a parent or another important person in the life of the child will not automatically result in unresolved grief or other negative outcomes if a

responsive attachment figure is present to help the child make sense of the loss. As the link between negative childhood events and negative outcomes is mitigated by attachment style, it is important to ask if those links remain stable across the lifespan. In other words, when poor parental bonding is linked with insecure attachment and negative behavioural outcomes during childhood, in the case of the current study unresolved mourning, do those links continue through to adulthood? The findings of Study 3 raise these questions unresolved bereavement in adulthood is preceded by poor bonding with parents only if an anxious attachment style is also reported in adulthood.

These questions are also relevant in Study 1 and they refer to the issue of continuity of attachment that has been discussed in the attachment literature. To what extent do attachment styles remain stable and to what extent do they change over time? Although the current studies did not look directly at stability of attachment patterns over time, the findings are relevant in some ways to this area of discussion. According to Bowlby (1969, 1980), working models of attachment are established early in life and have a critical influence on adult close relationships and mental health. Attachment working models therefore have been given trait-like qualities by Bowlby and other attachment researchers (Collins & Read, 1994).

This in some ways follows the notion introduced by Freud (1940), that early relationships with parents are prototypes for all subsequent ones and this has been known as the *prototype* perspective (Fraley, 2002). According to this perspective, attachment qualities remain stable over time. As individuals come across different life events and go through different life experiences their internal working models of self and other may be modified; however, the core of the early attachment representations based on parent–child interactions are less receptive of change and tend to remain relatively stable throughout the lifespan.

On the other hand, contemporary researchers have argued that although early attachment representations may exert a significant influence on development, they are also updated according to new life experiences. This has been known as the *revisionist* perspective (Fraley, 2002). For example, Groh et al. (2014) have found that attachment security is stable, specificly during infancy and late adolescence but becomes less so if the first 20 years of life are considered overall.

Changes in children's attachment pattern may be due to the fact the quality of parental care can change over time. For example, parents can be consistently uncaring but also can be relatively uncaring for a period and then improve, or become even less responsive due to changing life circumstances, such as changes in employment and financial situation and levels of stress, bereavement, or mental health problems (Waters et al., 2000). Main et al. (2005) report that change in attachment security is closely associated with trauma (death of parent/caregiver) directly experienced by the participant and that change in quality of parent caregiving and the psycho-physical responsiveness of the parent is closely linked to attachment discontinuity.

Depression in parents has been found to greatly affect the caregiving quality that their children receive. Studies have found that children of depressed mothers switch from a secure to an insecure attachment pattern between infancy and late adolescence more often that children of non-depressed mothers (National Research Council and Institute of Medicine, 2009). On the other hand, Beijersbergen and colleagues (Beijersbergen et al., 2012) report that mothers who became more responsive overtime had their adopted children's attachment security increased from infancy to adolescence. Nonetheless, in a meta-analytic study Fraley (2002) found that in the first 19 years of life patterns of stability are best explained by the prototype rather than the revisionist model, as attachment security is moderately stable during that period.

Research has shown that attachment representations of self and significant others inform new experiences with different relationships but they also result in developing relationship-specific qualities (Collins, 1996; Fraley, 2007). Firstly, studies suggest that children can develop different attachment patterns with different parents so these bonds can influence subsequent relationships in different ways. Fraley (2007) claims that while internal working models provide the general templates for relationships and self-regulation different aspects of those models can be activated in different contexts and different kinds of relationships. Using a connectionist framework this author explains how an individual mind can hold general attachment representations but also relationship-specific "rules" that are established over time in different relationships.

In a longitudinal study, Kirkpatrick and Hazan (1994), found that 70% of their adult participants showed stability in their attachment style over the period of four years providing strong support for the stability hypothesis. However, the study also suggested that a significant proportion did change their attachment style, raising questions about why that may have been so.

Brogaard (2015) argued that later experiences in life in adult romantic relationships may greatly influence individuals and make them revise their internal working models of attachment established early in life. Experience in personal relationships can mitigate the stability of change in adult attachment styles over the lifespan. Such relationships can include relationships with romantic partners who normally replace the primary caregiver's position as an attachment figure, but also with other peers who are emotionally close. These relationships can have a positive effect on the working models of attachment if they provide safety, confidence, and predictability in the relationship, but they can also have a negative influence if they bring anxiety, depression, and mistrust.

According to Brogaard, therefore, an individual's attachment style may fluctuate based on experiences with significant others in adulthood, as the new experiences interact with internal working models formed early in life in interactions with the caregiver. Negative experiences with partners and friends can turn the attachment security to insecurity while positive experiences can improve an initially insecure attachment pattern.

In a study assessing adult attachment style in a 6- and 48-month intervals, Davila and colleagues (Davila et al., 1997) found that adverse early experience often led to attachment fluctuation among recently graduating students, while there was a close similarity in relational qualities between women who showed attachment fluctuations and those with stably insecure attachments. These researchers argued that fluctuation in attachment styles is linked with a vulnerability to deal with changing circumstances in life – an individual is more vulnerable to life changes if the internal working models are incoherent while coherent mental models are less likely to undergo changes.

Working model coherence is directly linked with the emotional availability of the attachment figure. If an attachment figure is irregular and unpredictable in their responsiveness, the capacity of the self to deal with life stress is compromised. Insecure attachment style is the most likely outcome and major life events reactivate earlier experiences of instability. Such major life changes may include change of school, loss of peer network, severe break up or abandonment in relationships, teenage hormonal changes, and the death of a loved one. The authors also found that another important factor behind attachment style instability is a history of psychopathology, particularly personality disorder.

Fraley (2002) argues that the debate on attachment stability over the lifespan is hard to resolve and more longitudinal studies are needed. The prototype and revisionist perspectives seem to be based on different propositions and

understand differently the notion of attachment stability and the link between early attachment representations and later attachment styles. However, both perspectives accept the capacity for variability in attachment patterns during the lifespan. The findings of the present research, particularly of studies 1 and 2 need to be seen in light of the discussion on stability and change in attachment representations and in their links with dysfunctional psychological processes.

A third important issue that Study 3 touched upon was the transmission of ways of dealing with loss across generations, as in the bereaved sample parental complicated grief was positively correlated with all scales of child behavioural symptoms. The findings of Study 3 are consistent with a number of studies discussing the transmission of loss and trauma across generations (Belt et al., 2013; Zajac & Kobak, 2009). The correlational nature of the study however limits the strength of causal claims.

An additional barrier is the fact that no assessment of children's attachment style was conducted in Study 3, so no associations between that and parental attachment style can be made. The transmission of attachment patterns across generations can be closely linked to how loss through bereavement can also be intergenerationally transmitted, as those involve interpersonal relationships, support exchange, and emotional regulation. In a longitudinal study on the effects of caregiver unresolved loss beyond infancy, Zajac and Kobak (2009) found that the offspring of insecure caregivers suffering an unresolved loss consistently showed behavioural problems as older children and adolescents. According to Baradon (2010), what is important is not the loss itself that a child has suffered but whether this remains unresolved. This author argues that central in the process of resolution is the caregivers' state of mind. When loss remains unresolved in the caregiver's mind and the caregiver remains preoccupied with disorganised emotions, their interactions with the child will be negatively affected and the child's capacity to deal with the loss will be reduced.

The common thread in the three studies was how adult attachment style is linked with the childhood experience of bereavement and the findings seem compatible in many ways. The qualitative study indicated that individuals with an insecure attachment appeared more affected by the loss in their childhood. For example, the themes *Self is suppressing feelings, Self has somatic reactions*, *Self has psychological difficulties* were stronger in the accounts of dismissing individuals while *Self cannot understand death, Self is consumed*, and *Self is still affected* were stronger in preoccupied and fearful individuals. Study 2 confirmed that childhood loss has a different impact on adult perspective on that loss when bonding with parents and current attachment style are considered; Study 3 suggested that parental adult attachment style and bereavement experience may have an impact on how children experience loss.

In conclusion, the three studies addressed different aspects of the same issue – how attachment style in adults is linked with bereavement experience. So far, complicated grief and its link with attachment insecurity and the intergenerational transmission of complicated grief has been researched mainly in the context of the Adult Attachment Interview. The current study confirms and clarifies further these issues using appropriate self-report questionnaires and contributes in that way to the literature.

This study may help mental health professionals identify some useful strategies to support parents and children going through a bereavement experience. In particular, these findings may encourage relevant services to facilitate support for bereaved children and parents by focussing on the importance of parent attachment styles and parenting qualities. The present research might play a role in improving the parent–child attachment relationship, parent attachment style, and parenting style among bereaved families. It is important to involve suitable bereavement counsellors and professionals in support of parents and children going through bereavement.

Future research needs to include longitudinal designs that overcome the limitations of correlational studies and explore how parental attachment-related characteristics can predict parent–child relationship improvement and child behaviour adjustment overtime. Longitudinal studies could also clarify how such variables could predict intervention outcomes, particularly outcome of bereavement interventions. Moreover, future research needs to include more diverse samples, investigating how these research questions and hypotheses can be addressed in different cultural and socio-economic groups.

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APPENDICES

Appendix I – Forms and Questionnaires Study 1

The purpose of this study is to understand how children experience bereavement and how they remember that experience in adulthood. Research suggests that individuals' experience of bereavement is related with how the experience interpersonal relationships and this study also wishes to explore that link. The study is part of my PhD thesis in Psychology, under the supervision of Dr. Antigonos Sochos.

If you agree to take part this study, you will be interviewed by myself in a university room booked specifically for that purpose. The interview will take place at a time of your choice and if you agree, I will tape-recorded as it will be difficult for me to remember all the points you are making. I will ask you to tell me about the person (or loved pet) you lost, how you felt then, and how you feel about that now. The total time required to complete the study should be approximately 30 minutes.

Voluntary Nature of the Study/Confidentiality:

Your participation in this study is entirely voluntary and you may refuse to complete the interview or questionnaires at any point even if you initially agreed to take part. You can also refuse to answer any questions which you find uncomfortable and postpone at any point for a later time or date. You may pause at any time ask the researcher any questions you may have.

All information you provide will be strictly confidential and will be accessed only by myself and my supervisors. Your name will never appear on the questionnaires or interviews themselves or in any document that refers to the study. To identify your data a code number will be used. Information that would make it possible to identify you or any other participant will never be included in

any sort of report. You can ask for your data not to be used or to be returned to you any time you wish.

Statement of Consent:

In order to participate in this research study, it is necessary that you give your informed consent. By signing this informed consent statement you are indicating that you understand the nature of the research study and your role in that research and that you agree to participate in the research. Please consider the following points before signing:

- I understand that I am participating in psychological research;
- I understand that my identity will not be linked with my data, and that all information I provide will remain confidential;
- I understand that I will be provided with an explanation of the research in which I participated and be given the name and telephone number of an individual to contact if I have questions about the research.

I have read the above information. I have asked any questions I had regarding the research procedure and they have been answered to my satisfaction. I consent to participate in this study.

Signature of Participant _____Date: _____

This form will be detached from the data

Thank you for your participation!

Debrief Form (Study 1)

Thank you for participating in the study.

Do you have any questions or comments please?I wish to provide more information about the study. The study intends to extend existing research on the experience of bereavement, by researching that experience from a psychological perspective that emphasizes interpersonal relationships and the importance of interpersonal loss. I investigate the idea that the experience of bereavement will be informed by the child's interpersonal environment, particularly by the way he/she is supported by his/her parents. I am interested in understanding how bereavement is experienced in childhood but also how it is remembered in adulthood.

If you have further questions or comments do not hesitate to contact me Sadia Aleem at sadia.aleem@beds.ac.uk or my supervisor Dr Antigonos Sochos at antigonos.sochos@beds.ac.uk, Tel: 01234 400 400 ext. 2037.

If you feel that you have been in any way affected by your participation in this study and you wish to seek professional psychological support, please consult the following organizations:

Student Counselling Service, The Campus Centre, University Square, Luton LU1 3JU

Telephone: 01582 489338
Email: counselling@beds.ac.uk

CHUMS, Bereavement Service, Silsoe Research Institute, Wrest Park, Bedford, Bedfordshire MK45 4HSTel: 01525863924

Appendix DEMOGRAPHIC QUESTIONNAIRE (Study 1)

AGE: .....

MALE [ ] FEMALE [ ]

UNDERGRADUATE [ ] POST-GRADUATE [ ]

FIELD OF STUDY: .....

BRITISH NATIONAL [ ] NON-BRITISH NATIONAL [ ]

ETHNIC BACKGROUND

Black African [ ] Bangladeshi [ ] Pakistani [ ]

Black Caribbean [ ] Chinese [ ] White [ ]

Black Other ..... Indian [ ] Other .....

Mixed .....

MARITAL STATUS

Single [ ] Married/Cohabiting [ ]

Divorced [ ] Long term relationship (1 year or more) living in separate households [ ]

Separated [ ]

Semi-Structured Interview for Study 1

When students initially agree to take part in the study, before the interview proper begins, I will ask some questions to identify potential vulnerability in them. If participants answer Yes in any of the following questions I will politely explain to them that perhaps we should leave it for another time as the interview may be too upsetting for them.

Questions screening for vulnerability:

a. Could you say that the loss you wanted to talk about upset you a lot at the time

b. or that it upsets you today when you think about it?

c. Have you recently experienced a bereavement that has upset you greatly?

d. Could you say that you currently suffer or have recently suffered from psychological difficulties?

Semi-structured interview on childhood bereavement

- Ice-breakers
- Some what could you tell me about the person you lost in your childhood?
    - What was his/her relation to you?
- How old were you when you lost them – could you talk to me a bit about your life at that time?
    - Family situation, school, friends
- Was that person important to you in any way – why?
- Could you talk to me a bit about how you felt when you heard about the loss?

- How did you react – what did you do?
- How do you think people around you felt/reacted
    - Family, other relatives, kids
- As time was passing, how did you feel about it?
- Did you talk to anyone about how you were feeling (at any point)?
- Did anyone understand how you were feeling?
    - Did you feel supported by those around you at the time?
- Do you ever think about that person now – how do feel about them now?
    - And their loss
- Do you think your feelings have changed in any way about that between now and when you were a kid?
    - If yes, how
    - If no, why do you think nothing has changed although so much time has passed?
- Do you ever talk about that person/loss to anyone now?
    - If yes: Do you think people understand when you talk to them about it now
    - If not: Why not?
- If there was one main thing you could say about that experience what would that be?

Appendix II – Example of interview Transcript (Study 1)

Interviewer: Sadia Aleem

Interviewee: Participant1

SA: Can you tell me about the person you lost in your childhood?

P1: It was a friend of mine. I was at boarding school and I was at boarding school a . . . (pause) where many of the children came from the wealthy backgrounds and I did not. I came from South East of London and I was there on a grant and necessity place and a bursary and there was one other boy who was there under similar conditions for me so his parents were not of wealthy either. He was aback child and he was also from a very poor area of London me . . . so I sort of identified with him enough respect because we were different from most of the other children are boarding school and were seem away from home and I joined the boarding school in the summer term of the first year and then towards the end of the winter term of the second year, my friend died.

SA: Oh very sorry and he was the only friend you have at that time?

P1: No I had other friends, mostly girlfriends because when we were in the first and second year of boarding school because the girls were in the separate house from the boys obviously, at outside of lessons times as children, we socialised a lot because that's how we can spend time together (fire alarm)

SA: Do you want to talk more about the person?

P1: Yes, his name was Lynwool Cook but at that time there was programme got fame that was on TV, which was about the American dance school and that was a black guy in group Levoy, who was, em. . You know like a very good dancer. And so my friend was nicknamed Levoy, that's how everybody knew him. He was just a really very sweet boy. And I also say kind of identified with him, because of a,

you know we were with a similar background and we were different from a lot of the children at that school at that time. Yea.

SA: How old were you when you lost your friend?

I was twelve nearly thirteen.

SA: So you were very young. How was your life at that time? I mean how was your family situation?

P1: Aaa so we were at boarding school so we you know during term time we obviously stay like a boarding school. My parents separated when I was very young had been divorced for a long time and I mostly lived with my mum but I would also live with my dad as in my school he is went on and moved to live in and also at that time which have a still getting used to. Till eleven me and my brother being together but when I went to boarding school I was away from my brother as well. And. . . . So my family situation was they had been split up for a long time.

SA: Were you friendly and had a lot of friends in school?

P1: Yea I was em. . I was starting to make some very close friendships. It was still in nearly two terms in to that school but I think being in a boarding school the bonds that You build with your friends are may be closer than bonds you build a normal day school when go home after day classes

SA: So you have a lot of friends in your boarding school?

P1: Yea, I mean enough friends, yes, yes...

SA: How was your school situation? What type of student you were?

P1: Ye I was a studious you know I always worked hard and tried hard I can't

remember really what kind of student Levoy was because, I don't remember showing that many classes with him. I know that he was just like generally a very nice friendly, as open boy and he did not have any ass or graces and I think that was also why I was joined to him, usually a very nice company.

SA: Do you think that your friend was important in your life?

P1: Because I think of the similarities of the background we shared. Sometime when I used to go to school from London from where my mum was and, than I would see him like genie in school as well same time so I can it felt that our roots were similar, yea

SA: And when you heard news of his death news what was your reaction?

P1: I can remember that the house master came and we had an assembly which was first and second year together and so this would be an autumn term when I was in second year and house master stood up the front of the assembly and he just said I am sorry to say that Lenvoy is died last night and I can't remember anything else apart from that I was crying so much that I hadn't noticed that everybody else leave the lecture theatre which would have meant that some children would a kind of climb over me and leave the lecture theatre. The next thing I remember was a member of staff was coming up to me because I was sitting and crying and, than, I realized that I was the only child left in the lecture theatre where we had the assembly.

SA What did the other people around you they reacted?

P1: They were all crying but there wasn't. . I don't know I can't really remember anybody else. I remember that I was taken to my house matron and, than I re-joined classes letter n in the day and the children might obviously upset but they. . I don't remember anybody being as upset as I was because It was my first experience as a child I have ever losing any body.

SA: Obviously when you come to your home in holidays and you share your feelings to your parents or brother?

P1: I can't remember it ever discussing with my parents. I think I must have talked to my mum because I must have said but it would have been several weeks after that before was the end of the term before I saw my parents and the school I think sent a letter to parents saying that Envoy Cook had died and then I remember my mum because my mum knew who Levoy's mum was too, obviously from similar area in the south east London and the fact that you know she also know that there was also another child at that school in the similar circumstances she always said he looks like a nice boy and she had identified with the mother and often say hello to his mum but I can't remember really in depth discussions with my parents about it. No.

SA: He was close to you as compare to other students

P1: Yea I would say so I mean the thing was he died as a result of an asthmatic attack and it was one of my kind of boyfriends they were all having a kind of pillow fight and Levoy had an isthmic attack in pillow fight and died. I felt very bad for the boys who was just kind of involved in just normal childhood game, then resulted in death of one of them close friend they had been changed too much with. I really felt that they must felt terrible. I did feel really sorry for them I felt you know huge may have a loss Levoy death but I also felt that like these people do what a normal kind of people do feel really awful for playing a game and don't know of a child could have an isthmic attack can die as a result of the game

SA: As time was passing your feelings were changing gradually?

P1: Yea I think first two months were it was hard I felt extremely painfully and I would think about him and then n year of every anniversary day. You know I

have been thinking of him, remembering of this boy that had died at twelve years old and you know just thinking that this boy have never grown up to, lived the rest of his life. Yes in time it does lessen but you don't forget.

SA: Did you try to share your feelings to anyone at any point of life?

P1: Probably with my friends, yea. But I can't I know that I felt it very personally and yes we would have talked about it but I can't remember any conversation.

SA: Can you remember that anybody tried to console you?

P1: I think as friends we would have shared support for one another and I felt sad but I know that you know I was kind of people I remember they asked me it was almost like I was experiencing excessive grief compare to other children. I think that was apparent from the moment of being told that Levoy had died for several weeks afterwards it was same I was experiencing you know that people kept asking me but he was your boyfriend but it was almost like why are you so upset of him yes we all but why are you so upset about it, but I think I was a mixture of me as a person and you know feeling things very deeply and missing and feeling so sorry, missing this boy missing my friend, yea.

SA: So you mean you didn't get proper support that relaxes you mentally?

P1: No I mean I wouldn't say that it like criticise me because we all were upset together but I think it was definitely like why are you so upset about it, you know.

SA: Have you ever think about your friend now at this stage?

P1: Yes

SA: What are your feelings now?

P1: Most the same that you know was a shame that he never get to go up. That's the thing I feel really and I feel sorry for his family that they lost their son. Yea.

SA: Do you think your feelings have changed as compared to your childhood?

P1: I think they . . . . . it's hard because that time a twelve, thirteen years old you are very much in a moment of that time and I think any period in your life you are very much experiencing. What is happening in your life at that time and should grow up with. .so maybe you don't have the same intensity of feelings when you do think about it you feel sadness but you don't feel like I am sad. you feel that this was a sad thing that happened but you don't and you know that there is a feeling of sadness but you don't experience it at that same level when you are older looking back now.

SA: So your feelings are changed?

P1: Yes because you are not experiencing at that time but when you think about that person that no longer there than you still feel sad for it you still ad this I happened but you don't feel the huge sense of grief and loss at the time.

SA: Do you ever talk about your friend to anybody now?

Not really, I mean my come up once or twice if I used to meet up with friends school day we might talk about Levoy in past sense but other than that not .no

SA: If you can say a main thing about your childhood experience would what that is

P1: I think it would be how personal it was to me and how That didn't seem to affect people to the same degree, that it affected me at that time and as well as my grief Of loosing Levoy. I also had to do with the fact That other fact that other People thought my reaction was bordering on Excessive!

SA: Thank you for coming.

Appendix III – Forms and Questionnaires in Study 2

May I kindly ask you to participate in a psychological study that assesses experience of bereavement? If you agree to take part in the study, you will be asked to complete a questionnaire set, which will take 10-15 minutes. You will be asked to provide some information about bereavement you may have experienced before your 16th birthday.

Participation is completely voluntary and anonymous and confidential. You can withdraw from the study at any point if you so wish.

Statement of Consent:

In order to participate in this study, it is necessary that you give your informed consent. By ticking the box below you are indicating that you understand the nature of the research study and your role in that research and that you agree to participate.

Please consider the following points before signing:

- I understand that I am participating in psychological research;
- I understand that all information provided will be completely anonymous and confidential.
- I understand that I will be provided with an explanation of the research in which I participated and be given the name and telephone number of an individual to contact if I have questions about the research.
- I understand that I have the opportunity to ask questions.
- I understand I am free to withdraw.
- I understand that the results of this study might be used in research reports and academic publications in a numeric form and where the identification of participants will be impossible.

I have read the above information. I have asked any questions I had regarding the research procedure and they have been answered to my satisfaction. I consent to participate in this study. [ ]

Thank you for your participation!

DEBRIEF FORM (Study 2)

Thank you for participating in the study.

The study is part of my PhD thesis in Psychology, under the supervision of Dr. AntigonosSochos, Department of Psychology, University of Bedfordshire. The study intends to extend existing research on the experience of bereavement, by researching that experience from an interpersonal perspective.

This study will assess the some substantial bereavement experience during childhood and teen age. The present study wishes to extend our knowledge on this area.

If you have questions or comments do not hesitate to tell me in person or contact me at sadia.aleem@beds.ac.uk. You may also contact my supervisorDrAntigonosSochos at antigonos.sochos@beds.ac.uk, Tel: 01234 400 400 ext. 2037.

If you feel that you have been in any way affected by your participation in this study and you wish to seek professional psychological support, please consult the following organizations:

CHUMS, Bereavement Service, Silsoe Research Institute, Wrest Park, Bedford, Bedfordshire MK45 4HSTel: 01525863924

Many thanks for your participation

DEMOGRAPHIC QUESTIONNAIRE (Study 2)

AGE: .....

GENDER:MALE [ ] FEMALE [ ]

ETHNIC BACKGROUND

Black African [ ] Bangladeshi [ ] Pakistani [ ]

Black Caribbean [ ] Chinese [ ] White [ ]

Black Other ..... Indian [ ] Other .....

Mixed .....

MARITAL STATUS

Single [ ] Married/Cohabiting [ ]

Divorced [ ] Long term relationship (1 year or more) living in separate households [ ]

Separated [ ]

Inventory Of Complicated Grief (Study 2& 3)

Please think of the death of a person that you feel has affected you the most, regardless of when the loss occurred. The person may or may not be the same as the above person your child lost. Tick the boxes that best describe how you feel.

Never means less than once monthly

Rarely means more than once monthly but less than once weekly

Sometimes means more than weekly but less than daily

Often means about daily

Always means more than once daily

What was your relationship with the deceased:_____

How long ago did the loss occur:_____

Items	Never 0	Rarely 1	Some Times 2	Often 3	Always 4
1. I think about this person so much that it's hard for me to do the things I normally do					
2. Memories of the person who died upset me					
3. I cannot accept the death of the person who died					
4. I feel myself longing for the person who died					
5. I feel drawn to places and things associated with the person who died					
6. I can't help feeling angry about his/her death					
7. I feel disbelief over what happened					

8. I feel stunned or dazed over what happened					
9. Ever since s/he died it is hard for me to trust people					
10. Ever since s/he died I feel like I have lost theability to care about other people / I feel distantfrom people I care about					
11. I have pain in the same area of my bodyor I have some of the same symptoms as the person who died					
12. I go out of my way to avoid reminders of the person who died					
13. I feel that life is empty without the person who died					
14. I hear the voice of the person who died speak to me					
15. I see the person who died stand before me					
16. I feel that it is unfair that I should live when this person died					
17. I feel bitter over this person's death					
18. I feel envious of others who have not lost someoneclose					
19. I feel lonely a great deal ofthe time ever since s/hedied					

Parental Bonding Instrument (PBI)(Study2)

This questionnaire lists various attitudes and behaviours of parents.

MOTHER FORM: As you remember your **MOTHER** in your first 16 years would you circle the most appropriate response.				
Items	**Very Like Her**	**Moderately Like Her**	**Moderately Unlike Her**	**Very Unlike Her**
1. Spoke to me in a warm and friendly voice				
2. Did not help me as much as I needed				
3. Let me do those things I liked doing				
4. Seemed emotionally cold to me				
5. Appeared to understand my problems and worries				
6. Was affectionate to me				
7. Liked me to make my own decisions				
8. Did not want me to grow up				
9. Tried to control everything I did				
10. Invaded my privacy				
11. Enjoyed talking things over with me				
12. Frequently smiled at me				

13. Tended to baby me				
14. Did not seem to understand what I needed or wanted				
15. Let me decide things for myself				
16. Made me feel I wasn't wanted				
17. Could make me feel better when I was upset				
18. Did not talk with me very much				
19. Tried to make me feel dependent on her				
20. Felt I could not look after myself unless she was around				
21. Gave me as much freedom as I wanted				
22. Let me go out as often as I wanted				
23. Was overprotective of me				
24. Did not praise me				
25. Let me dress in any way I pleased				

Please now complete the FATHER FORM:

FATHER FORM: As you remember your **FATHER** in your first 16 years would you circle the most appropriate response.

Items	Very Like Him	Moderately Like Him	Moderately Unlike Him	Very Unlike Him
1. Spoke to me in a warm and friendly voice				
2. Did not help me as much as I needed				
3. Let me do those things I liked doing				
4. Seemed emotionally cold to me				
5. Appeared to understand my problems and worries				
6. Was affectionate to me				
7. Liked me to make my own decisions				
8. Did not want me to grow up				
9. Tried to control everything I did				
10. Invaded my privacy				
11. Enjoyed talking things over with me				
12. Frequently smiled at me				
13. Tended to baby me				

14. Did not seem to understand what I needed or wanted				
15. Let me decide things for myself				
16. Made me feel I wasn't wanted				
17. Could make me feel better when I was upset				
18. Did not talk with me very much				
19. Tried to make me feel dependent on him				
20. Felt I could not look after myself unless he was around				
21. Gave me as much freedom as I wanted				
22. Let me go out as often as I wanted				
23. Was overprotective of me				
24. Did not praise me				
25. Let me dress in any way I pleased				

SEPARATION ANXIETY SYMPTOM INVENTORY (SASI) (Study2)

Appendix 1 The following statements refer to fears you might have had in early life. Please tick once the appropriate brackets for each item, according to your memories before 18 years. Please remember to answer all questions

Before age 18 years .....

	(A) Excluded items:	**This feeling occurred very often 1**	**This feeling occurred fairly often 2**	**This feeling occurred occasionally 3**	**I never had this feeling 4**
1	I felt uncomfortable about leaving home alone				
2	I was not keen to sleep at friends				
3	I wanted to be very close to my mother				
4	I wanted to be very close to my father				
5	I felt unloved and uncared for				
6	I was homesick when I was far away from home				
7	I was worried that I might be rejected by my family				
8	I did not want to go to school				
9	I feared that one of my parents might come to harm when I was away from home				
10	I did not want to be left alone at home				
11	I had physical symptoms like stomach aches, nausea, headaches, before going to school				
12	I had fears that accidents might happen to members of my family when I was not with them				
13	I was afraid of getting lost when I was in strange places				
14	I imagined that monsters or animals might attack me when I was alone at night				
15	I was very afraid of strangers when I was on my own				
16	I had nightmares about violence towards me or my family				
17	I was very unhappy if I was separated from my family				

18	I was afraid of being harmed or kidnapped when I was alone				
19	I daydreamed about being with my family when I was away from home				
20	I was afraid to go to sleep alone				
21	I was very tense before going to school				
22	I was afraid of the dark				

Appendix IV – Forms and Questionnaires for Study 3

Participant Information Consent Form

(Bereaved-groupStudy 3)

The experience of bereavement among children and parents

May I kindly ask you to participate in a study of the experience of bereavement among children and parents? The aim of the study is to understand how children and adults experience bereavement and what the role if interpersonal relationships are in that experience.

If you agree to take part in the study, you will be asked to complete a questionnaire set, which will take 10-15 minutes. You will be asked to identify a person that your child has recently lost andprovide some information on your child's behaviour. You will also be asked about a loss of yours (that may or may not be the same person) and your feelings about it.

Participation is completely voluntary, anonymous, and confidential. You can withdraw from the study at any point.

<u>Statement of Consent</u>:

In order to participate in this study, it is necessary that you give your informed consent. By ticking the box below you are indicating that you understand the nature of the research study and your role in that research and that you agree to participate.

Please consider the following points before signing:

- I understand that I am participating in psychological research;
- I understand that all information provided will be completely anonymous and confidential.

- I understand that I will be provided with an explanation of the research in which I participated and be given the name and telephone number of an individual to contact if I have questions about the research.
- I understand that I have the opportunity to ask questions.
- I understand I am free to withdraw.
- I understand that the results of this study might be used in research reports and academic publications in a numeric form and where the identification of participants will be impossible.

I have read the above information. I have asked any questions I had regarding the research procedure and they have been answered to my satisfaction. I consent to participate in this study. [ ]

Thank you for your participation

Participant Information Consent Form(non-bereaved-group(Study 3)

The experience of bereavement among children and parents

May I kindly ask you to participate in a psychological study that compares children and parents with an experience of bereavement and those without such an experience? If you agree to take part in the study, you will be asked to complete a questionnaire set, which will take 10-15 minutes. You will be asked to provide some information on your child's behavior and also about bereavement you may have experienced.

Participation is completely voluntary and anonymous and confidential. You can withdraw from the study at any point if you so wish.

<u>Statement of Consent</u>:

In order to participate in this study, it is necessary that you give your informed consent. By ticking the box below you are indicating that you understand the nature of the research study and your role in that research and that you agree to participate.

Please consider the following points before signing:

- I understand that I am participating in psychological research;
- I understand that all information provided will be completely anonymous and confidential.

- I understand that I will be provided with an explanation of the research in which I participated and be given the name and telephone number of an individual to contact if I have questions about the research.
- I understand that I have the opportunity to ask questions.
- I understand I am free to withdraw.

- I understand that the results of this study might be used in research reports and academic publications in a numeric form and where the identification of participants will be impossible.

I have read the above information. I have asked any questions I had regarding the research procedure and they have been answered to my satisfaction. I consent to participate in this study. [ ]

Thank you for your participation!

DEBRIEF FORM (Study 3)

Thank you for participating in the study.

The study is part of my PhD thesis in Psychology, under the supervision of Dr. AntigonosSochos, Department of Psychology, University of Bedfordshire. The study intends to extend existing research on the experience of bereavement, by researching that experience from an interpersonal perspective.

This study will compare the two groups of parents - parents (primary caregivers) of children who have undergone some substantial bereavement and parents of children with no such bereavement experience.

Previous studies have shown that the quality of the parent-child bond and previous experience of parental bereavement has an impact on how children experience bereavement themselves. The present study wishes to extend our knowledge on this area.

If you have questions or comments do not hesitate to tell me in person or contact me at sadia.aleem@beds.ac.uk. You may also contact mysupervisorDrAntigonosSochos at antigonos.sochos@beds.ac.uk, Tel: 01234 400 400 ext. 2037.

If you feel that you have been in any way affected by your participation in this study and you wish to seek professional psychological support, please consult the following organizations:

CHUMS, Bereavement Service, Silsoe Research Institute, Wrest Park, Bedford, Bedfordshire MK45 4HSTel: 01525863924

Many thanks for your participation

DEMOGRAPHIC INFORMATION ABOUT THE PARENT HAVING A BEREAVED CHILD

AGE: .....

MALE [ ] FEMALE [ ]

BRITISH NATIONAL [ ] NON-BRITISH NATIONAL [ ]

ETHNIC BACKGROUND

Black African [ ] Bangladeshi [ ] Pakistani [ ] Black Caribbean [ ] Chinese []

White [ ] Black Other ..... Indian [ ] Other ..... Mixed .....

MARITAL STATUS

Single [ ] Married/Cohabiting [ ] Divorced [ ]

In relationship, separate households [ ] Separated [ ]

EDUCATIONAL QUALIFICATIONS

University[ ] Further Education College [ ] A-Level [ ] GCSE [ ] Lower than GSCE [ ]

BEREAVEMENT INFORMATION

1. What was the relationship of the deceased with the child?_____

Parent [ ] Grand-parent [ ] Sibling [ ] Other relative [ ] Friend [ ]

2. How long ago did the child lose the person ? _____

3. How close was the deceased with the child you will tell us about

Very close [ ] Close [ ] Neither close Nor distant [ ] Not close[ ]

Not at all close [ ]

DEMOGRAPHIC INFORMATION ABOUT THE PARENT HAVING A NON-BEREAVED CHILD

AGE: .....

MALE [ ] FEMALE [ ]

BRITISH NATIONAL [ ] NON-BRITISH NATIONAL [ ]

ETHNIC BACKGROUND

Black African [ ] Bangladeshi [ ] Pakistani [ ] Black Caribbean [ ] Chinese []

White [ ] Black Other ..... Indian [ ] Other ..... Mixed .....

MARITAL STATUS

Single [ ] Married/Cohabiting [ ] Divorced [ ]

In relationship, separate households [ ] Separated [ ]

EDUCATIONAL QUALIFICATIONS

University[ ] Further Education College [ ] A-Level [ ] GCSE [ ] Lower than GSCE [ ]

CHILD STRESS QUESTIONNAIRE

Please circle **2** if the item is **VERY TRUE** of your child, **1: SOMEWHAT TRUE, 0:NOT TRUE.**

Please answer all items as well as you can even if some do not seem to apply to your child.

A. **How did your child behave immediately after the loss:**

Items	Not True 0	Somewhat True 1	Very True 2
1. Felt terrified (extreme anxiety or fear)			
2. Felt horrified (extreme feelings of revulsion, disgust, or shame)			
3. Felt helpless			
4. Child's behaviour became agitated. For example, his or her behaviour became hyperactive, impulsive, or difficult to control.			
5. Child's behaviour became disorganised. For example his or her behaviour became very different than is usual, his/her behaviour did not make sense.			

B. Please indicate how your child behaves <u>now</u>

Items	Not	Somewhat	Very

	True 0	True 1	True 2
1. Child reports uncomfortable memories of the event.			
2. Child startles easily. For example, he or she jumps when hears sudden or loud noises.			
3. Child gets very upset if reminded of the event.			
4. Child seems numb or distant from his or her feelings.			
5. Child avoids doing things that remind him or her of the event.			
6. Child seems irritable or angry.			
7. Child has difficulty remembering details about the event			
8. Child has difficulty falling asleep or staying asleep.			
9. Child seems detached or distant from other people.			
10. Child has difficulty getting along with friends, schoolmates or teachers.			
11. Child does things that s/he outgrew - e.g. thumb sucking, bedwetting; nail biting, requests to sleep with			

parents.			
12. Child reports feeling as if the event were happening again.			
13. Child is restless and doesn't sit still.			
14. Child avoids places that remind him or her of the event			
15. Child has difficulty getting along with family members.			
16. Child appears confused about things that he or she should know.			
17. Child seems "on edge" or nervous			
18. Child seems "spaced out" or in a daze.			
19. Child acts as if the event were happening again.			
20. Child has trouble keeping track of time, becomes confused about the time of day, the day of the week, or when something really happened.			
21. Child avoids talking about the event.			
22. Child reports bad dreams.			
23. Child reports more physical complaints when reminded of the event – e.g. headachesstomach aches,			

nausea, difficulty breathing.			
24. Child has difficulty performing activities such as schoolwork or chores.			
25. Child plays about the event (expresses what happened to him or her with toys, games, drawings, fantasy-play).			
26. Child appears slowed down. It takes him or her a long time to respond to things.			
27. Child reports that his or her environment seems different than it used to – e.g. that things look or sound different.			
28. Child avoids people who remind him or her of the event.			
29. Child has trouble concentrating			
30. Child reports that he or she does not want to think about the event			

QUESTIONNAIRE SD 1

for 3 and 4 year old children

Please indicate how true each of the following statements is. The statements refer to how your child is and what s/he does.

Items	Not True 0	Somewhat True 1	Certainly True 2
1. Considerate of other people's feelings			
2. Restless, overactive, cannot stay still for long			
3. Often complains of headaches, stomach-aches or sickness			
4. Shares readily with other children (treats,toys,pencils etc.)			
5. Often has temper tantrums or hot tempers			
6. Rather solitary, tends to play alone			
7. Generally obedient, usually does what adults request			
8. Many worries, often seems worried			
9. Helpful if someone is hurt, upset or feeling ill			
10. Constantly fidgeting or squirming			
11. Has at least one good friend			
12. Often fights with other children or bullies them			

13. Often unhappy, downhearted or tearful			
14. Generally liked by other children			
15. Easily distracted, concentration wanders			
16. Nervous or clingy in new situations, easily loses confidence			
17. Kind to younger children			
18. Often argumentative with adults			
19. Picked on or bullied by other children			
20. Often volunteers to help others (parents, teachers, children)			
21. Can stop and think things over before acting			
22. Can be spiteful to others			
23. Gets on better with adults than with other children			
24. Many fears, easily scared			
25. Sees tasks through to the end, good attention span			

QUESTIONNAIRE SD2

for children over 4 years old

Please indicate how true each of the following statements is. The statements refer to how your child is and what s/he does.

Items	**Not True** **0**	**Somewhat True** **1**	**Certainly True** **2**
1. Considerate of other people's feelings			
2. Restless, overactive, cannot sit still for long			
3. Often complains of headaches, stomach-aches or sickness			
4. Shares readily with other children (treats,toys,pencils)			
5. Often has temper tantrums or hot tempers			
6. Rather solitary, tends to play alone			
7. Generally obedient, usually does what adults request			
8. Many worries, often seems worried			
9. Helpful if someone is hurt, upset or feeling ill			
10. Constantly fidgeting or squirming			
11. Has at least one good friend			

12. Often fights with other children or bullies them			
13. Often unhappy, downhearted or tearful			
14. Generally liked by other children			
15. Easily distracted, concentration wanders			
16. Nervous or clingy in new situations, easily loses confidence			
17. Kind to younger children			
18. Often lies or cheats			
19. Picked on or bullied by other children			
20. Often volunteers to help others (parents, teachers, other children)			
21. Thinks things out before acting			
22. Steals from home, school or elsewhere			
23. Gets on better with adults than with other children			
24. Many fears, easily scared			
25. Sees tasks through to the end, good attention span			

ECR QUESTIONNAIRE (Studies 1, 2 & 3)

The statements below concern how you feel in emotionally intimate relationships. We are interested in how you ***generally*** experience relationships, not just in what is happening in current relationships. Respond to east statement by ticking a box to indicate how much you agree or disagree with the statement.

1	2	3	4	5	6	7
Disagree Strongly			Neutral/ Mixed			Agree Strongly

	Items	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1.	I prefer not to show a partner how I feel deep down							
2.	I worry about being abandoned							
3.	I am very comfortable being close to romantic partners							
4.	I worry a lot about my relationships							
5.	Just when my partner starts to get close to me I find myself pulling away							
6.	I worry that romantic partners won't care about me as much as I care about them							
7.	I get uncomfortable when a romantic partner wants to be very close							
8.	I worry a fair amount about losing my partner							
9.	I don't feel comfortable opening up to romantic partners							
10.	I often wish that my partner's feelings							

	for me were as strong as my feelings for him/her							
11.	I want to get close to my partner, but I keep pulling back							
12.	I often want to merge completely with romantic partners, and this sometimes scares them away							
13.	I am nervous when partners get too close to me							
14.	I worry about being alone							
15.	I feel comfortable sharing my private thoughts and feelings with my partner							
16.	My desire to be very close sometimes scares people away							
17.	I try to avoid getting too close to my partner							
18.	I need a lot of reassurance that I am loved by my partner							
19.	I find it relatively easy to get close to my partner							
20.	Sometimes I feel that I force my partners to show more feeling, more commitment							
21.	I find it difficult to allow myself to depend on romantic partners							
22.	I do not often worry about being abandoned							
23.	I prefer not to be too close to romantic partners							

24.	If I can't get my partner to show interest in me, I get upset or angry								
25.	I tell my partner just about everything								
26.	I find that my partner(s) don't want to get as close as I would like								
27.	I usually discuss my problems and concerns with my partner								
28.	When I'm not involved in a relationship, I feel somewhat anxious and insecure								
29.	I feel comfortable depending on romantic partners								
30.	I get frustrated when my partner is not around as much as I would like								
31.	I don't mind asking romantic partners for comfort, advice, or help								
32.	I get frustrated if romantic partners are not available when I need them								
33.	It helps to turn to my romantic partner in times of need								
34.	When romantic partners disapprove of me, I feel really bad about myself								
35.	I turn to my partner for many things, including comfort and reassurance								
36.	I resent it when my partner spends time away from me								
		1	**2**	**3**	**4**	**5**	**6**	**7**	

Disagree Strongly			**Neutral/Mixed**			**Agree Strongly**
1	**2**	**3**	**4**	**5**	**6**	**7**

Appendix V – Results tables for Study 3

Appendix V Table 1:

Moderating effects of attachment anxiety on the link between bereavement status and child behavioural problems.

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df*	
								*df*1	*df2*
SDQ-Emotional-Problem	Step1								
	Constant								
	Parent-Age		.045						
	Parent-Gender	.007	.901						
		.049	.409	.244	.228	15.102	<.001	5	234
	ECR-Avoidance	.019	.814						
	PS- Total	.096	.155						
	Parent-Complicated-Grief	.394	.000						
	Step 2								
	Bereavement-Status	-.330	052	.245	.222	.084	.919	2	232
	ECR-Anxiety	-.089	.380						
	Step 3								
	Bereavement-StatusXECR-Anxiety	.390	.040	.258	.233	4.283	.040	1	231

SDQ-Conduct-Problem	Step1								
	Constant								
	Parent-Age		.000						
	Parent-Gender	-.058	.309						
	ECR-Avoidance	-.095	.105	.239	.223	14.723	<.001	5	234
	PS- Total	.180	.028						
	Parent-Complicated-Grief	.084	.205						
	Step 2	.297	.000						
	Bereavement-Status	-.624	.000	.244	.221	.656	.444	2	232
	ECR-Anxiety	-.227	.024						
	Step 3								
	Bereavement-StatusXECR-Anxiety	.666	<.001	.284	.259	12.944	<.001	1	231
SDQ-Hyperactivity	Step1								
	Constant								
	Parent-Age		.006						
	Parent-Gender	-.023	.682						
	ECR-Avoidance	.048	.410	.246	.230	15.245	<.001	5	234
	PS- Total	.168	.039						
	Parent-Complicated-	.127	.054						
		.279	.000						

	Grief Step 2								
	Bereavement-Status	-.556	.001	.271	.249	4.093	.018	2	232
	ECR-Anxiety	-.095	.339						
	Step 3								
	Bereavement-StatusXECR-Anxiety	.461	.013	.291	.266	6.268	.013	1	231
SDQ-Peer-Problem	Step1								
	Constant								
	Parent-Age		.018						
	Parent-Gender	-.029	.606						
	ECR-Avoidance	-.038	.512	.253	.237	15.868	<.001	5	234
	PS- Total	.300	.000						
	Parent-Complicated-Grief	.059	.369						
	Step 2	.168	.014						
	Bereavement-Status	-.479	.004	.277	.256	3.897	.022	2	232
	ECR-Anxiety	-.047	.634						
	Step 3								
	Bereavement-StatusXECR-Anxiety	.380	.040	.291	.266	4.252	.040	1	231
SDQ-Prosocial	Step1								
	Constant		.015	.204	.187	11.973	<.001	5	234

	Parent-Age	.032	.591						
	Parent-Gender	.002	.970						
	ECR-Avoidance	-.074	.390						
	PS- Total	.013	.849						
	Parent-Complicated-Grief	.419	.000						
	Step 2								
	Bereavement-Status	.014	.934	.211	.187	1.023	.361	2	232
	ECR-Anxiety	.054	.607						
	Step 3								
	Bereavement-StatusXECR-Anxiety	.065	.739	.211	.184	.111	.739	1	231
	Step1								
	Constant		.000						
	Parent-Age		.762						
	Parent-Gender	-.016	.933						
SDQ-Total	ECR-Avoidance	-.007	.048	.374	.352	17.230	<.001	5	234
	PS- Total	.151	.100						
	Parent-Complicated-Grief	.068	.000						
	Step 2			.380	.353	1.242	.291	2	232

Bereavement-Status	.043	.001						
ECR-Anxiety	.007	.2741						
Step 3								
Bereavement-StatusXECR-Anxiety	.420	.003	.402	.373	8.239	.004	1	231

Appendix V Table 2:

Moderating effects of attachment avoidance on the link between bereavement status and child behavioural problems.

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	p
SDQ-Emotional-Problem	Step1		.281	.244	.228	15.103	<.001
	Constant	-.004	.949				
	Parent-Age	.051	.394				
	Parent-Gender	.034	.685				
	ECR-Anxiety	.085	.211				
	PS- Total	.421	.000				
	Parent-Complicated-Grief						
	Step 2						
	Bereavement-Status	-.011	.957	.245	.222	.083	.921
	ECR-Avoidance	.029	.814				
	Step 3						
	Bereavement-StatusXECR-Avoidance	.007	.973	.245	.218	.001	.973
SDQ-Conduct-Problem	Step1		.002	.233	.206	13.018	<.001
	Constant	-.074	.208				
	Parent-Age	-.098	.105				
	Parent-Gender	.001	.986				
	ECR-Anxiety	.069	.304				

	PS- Total	.334	.000				
	Parent-Complicated-Grief						
	Step 2						
	Bereavement-Status	-.373	.070	.255	.223	3.980	.020
	ECR-Avoidance	.060	.626				
	Step 3						
	Bereavement-StatusXECR-Avoidance	.347	.121	.264	.228	2.420	.121
	Step1						
	Constant		.005				
	Parent-Age	-.031	.581				
	Parent-Gender	.042	.475	.225	.208	13.558	<.001
	ECR-Anxiety	.076	.352				
	PS- Total	.120	.069				
SDQ-Hyperactivity	Parent-Complicated-Grief	.297	.000				
	Step 2						
	Bereavement-Status	-.591	.004	.271	.249	7.448	.001
	ECR-Avoidance	-.012	.920				
	Step 3						
	Bereavement-StatusXECR-	.478	.029	.286	.262	4.822	.029

	Avoidance						
SDQ-Peer-Problem	Step1						
	Constant		.021				
	Parent-Age	-.037	.522				
	Parent-Gender	-.042	.469	.199	.182	11.657	<.001
	ECR-Anxiety	.091	.264				
	PS- Total	.053	.423				
	Parent-Complicated-Grief	.184	.007				
	Step 2						
	Bereavement-Status	-.470	.020	.277	.256	12.533	<.001
	ECR-Avoidance	.169	.162				
	Step 3						
	Bereavement-StatusXECR-Avoidance	.351	.108	.286	.261	2.596	.108
SDQ-Prosocial	Step1						
	Constant		.053				
	Parent-Age	.030	.617				
	Parent-Gender	.004	.953	.203	.186	11.945	<.001
	ECR-Anxiety	.072	.403				
	PS- Total	.011	.877				
	Parent-Complicated-Grief	.425	.000				
	Step 2			.211	.187	1.079	.342

	Bereavement-Status	.111	.599				
	ECR-Avoidance	-.052	.683				
	Step 3						
	Bereavement-StatusXECR-Avoidance	-.048	.833	.211	.184	.044	.833
SDQ-Total	Step1						
	Constant		.001				
	Parent-Age	-.027	.607				
	Parent-Gender	-.007	.901	.357	.343	25.940	<.001
	ECR-Anxiety	.075	.325				
	PS- Total	.089	.147				
	Parent-Complicated-Grief	.448	.000				
	Step 2						
	Bereavement-Status	-.336	.073	.378	.359	4.027	.019
	ECR-Avoidance	.048	.669				
	Step 3						
	Bereavement-StatusXECR-Avoidance	.286	.159	.384	.362	1.998	.159

Appendix V Table 3:

Moderating effects of parental complicated grief on the link between bereavement status and child problems.

Dependent Variables	**Independent Variables**	**Beta**	***p***	**R^2**	**Adj R^2**	**ΔF**	***p***	***df1***	***df2***
SDQ-Emotional-Problem	Step1			.116	.097	6.153	<.001	5	234
	Constant		.217						
	Parent-Age	-.004	.946						
	Parent-Gender	.051	.395						
	ECR-Avoidance	.032	.698						
	ECR-Anxiety	.033	.688						
	PS- Total	.085	.212						
	Step 2			.245	.222	19.701	<.001	2	232
	Bereavement-Status	-.025	.853						
	Parent-Complicated-Grief	.404	.001						
	Step 3			.245	.218	.029	.864	1	231

	Bereavement-StatusX Parent-Complicated-Grief	.032	.864						
SDQ-Conduct-Problem	Step1			.162	.144	9.043	<.001	5	234
	Constant		.001						
	Parent-Age	-.078	.180						
	Parent-Gender	-.095	.113						
	ECR-Avoidance	.204	.014						
	ECR-Anxiety	-.020	.808						
	PS- Total	.064	.341						
	Step 2			.244	.221	12.521	<.001	2	232
	Bereavement-Status	-.294	.031						
	Parent-Complicated-Grief	.155	.206						
	Step 3			.255	.229	3.462	.064	1	231
	Bereavement-	.34	.06						

	StatusX Parent-Complicated-Grief	7	4						
SDQ-Hyperactivity	Step1			.194	.177	11.280	<.001	5	234
	Constant		.087						
	Parent-Age	-.037	.525						
	Parent-Gender	.051	.391						
	ECR-Avoidance	.183	.026						
	ECR-Anxiety	.050	.538						
	PS- Total	.114	.087						
	Step 2			.271	.249	12.291	<.001	2	232
	Bereavement-Status	-.175	.193						
	Parent-Complicated-Grief	.309	.012						
	Step 3			.271	.246	.001	.973	1	231
	Bereavement-StatusX Parent-Complicated-	.006	.973						

	Grief								
SDQ-Peer-Problem	Step1			.238	.222	14.606	<.001	5	234
	Constant		.098						
	Parent-Age	-.040	.481						
	Parent-Gender	-.037	.535						
	ECR-Avoidance	.313	.000						
	ECR-Anxiety	.072	.375						
	PS- Total	.048	.467						
	Step 2			.277	.256	6.361	.002	2	232
	Bereavement-Status	-.198	.140						
	Parent-Complicated-Grief	.166	.172						
	Step 3			.278	.253	.089	.765	1	231
	Bereavement-StatusX Parent-Complicated-Grief	.055	.765						

SDQ-Prosocial	Step1			.065	.045	3.278	.007	5	234
	Constant		.064						
	Parent-Age	.031	.605						
	Parent-Gender	.005	.939						
	ECR-Avoidance	-.073	.393						
	ECR-Anxiety	.076	.372						
	PS- Total	.012	.865						
	Step 2			.211	.187	21.344	<.001	2	232
	Bereavement-Status	.184	.188						
	Parent-Complicated-Grief	.521	.000						
	Step 3			.214	.186	.869	.352	1	231
	Bereavement StatusX Parent-Complicated Grief	-.178	.352						

Appendix V Table 4:

Moderating effects of parenting style on the link between bereavement status and child problems.

Dependent Variables	**Independent Variables**	**Beta**	***p***	**R^2**	**Adj R^2**	**ΔF**	***p***	***df*** ***df*1**	***d***
SDQ-Emotional-Problem	Step1			.239	.223	14.728	<.001	5	2
	Constant		.582						
	Parent-Age	-.010	.866						
	Parent-Gender	.048	.423						
	ECR-Avoidance	.045	.581						
	ECR-Anxiety	.014	.863						
	Parent-Complicated-Grief	.433	.000						
	Step 2			.250	.228	1.704	.184	2	2
	Bereavement-Status	.170	.363						
	PS-Laxness	.176	.048						
	Step 3			.253	.228	.931	.336	1	2
	Bereavement-StatusXPS-Laxness	-.192	.336						
SDQ-Conduct-Problem	Step1		.018	.237	.221	14.523	<.001	5	2
	Constant	-.076	.199						
	Parent-Age	-.084	.165						
	Parent-Gender	.233	.004						

	ECR-Avoidance	-.006	.944						
	ECR-Anxiety	.345	.000						
	Parent-Complicated-Grief								
	Step 2			.241	.218	.591	.554	2	2
	Bereavement-Status	.063	.740						
	PS-Laxness	.033	.712						
	Step 3			.242	.216	.524	.470	1	2
	Bereavement-StatusXPS-Laxness	-.145	.470						
SDQ-Hyperactivity	Step1			.238	.222	14.656	<.001	5	2
	Constant		.219						
	Parent-Age	-.040	.483						
	Parent-Gender	.049	.412						
	ECR-Avoidance	.206	.010						
	ECR-Anxiety	.040	.627						
	Parent-Complicated-Grief	.321	.000						
	Step 2			.272	.250	5.397	.005	2	2
	Bereavement-Status	-.015	.937						
	PS-Laxness	.165	.060						
	Step 3			.275	.250	.752	.387	1	2

	Bereavement-StatusXPS-Laxness	-.170	.387						
SDQ-Peer-Problem	Step1			.254	.238	15.923	<.001	5	2
	Constant								
	Parent-Age		.106						
	Parent-Gender	-.040	.488						
		-.040	.495						
	ECR-Avoidance	.315	.000						
	ECR-Anxiety	.073	.372						
	Parent-Complicated-Grief	.195	.004						
	Step 2			.278	.257	3.933	.021	2	2
	Bereavement-Status	-.226	.220						
		.032	.714						
	PS-Laxness								
	Step 3			.279	.254	.144	.704	1	2
	Bereavement-StatusXPS-Laxness	.074	.704						
SDQ-Prosocial	Step1			.207	.190	12.181	<.001	5	2
	Constant		.119						
	Parent-Age	.024	.683						
	Parent-Gender	.006	.928						
		-.065	.435						
	ECR-Avoidance	.056	.509						
		.434	.000						

	ECR-Anxiety								
	Parent-Complicated-Grief								
	Step 2			.211	.188	.704	.496	2	2
	Bereavement-Status	.310	.106						
		.115	.205						
	PS-Laxness								
	Step 3			.217	.190	1.782	.183	1	2
	Bereavement-StatusXPS-Laxness	-.272	.183						
SDQ-Total	Step1			.367	.354	27.176	<.001	5	2
	Constant								
	Parent-Age		.036						
	Parent-Gender	-.034	.519						
		-.002	.975						
	ECR-Avoidance	.184	.013						
	ECR-Anxiety	.048	.522						
	Parent-Complicated-Grief	.465.	.000						
	Step 2			.379	.360	2.100	.125	2	2
	Bereavement-Status	.091	.594						
		.143	.077						
	PS-Laxness								
	Step 3			.382	.360	1.138	.287	1	2
	Bereavement-StatusXPS-Laxness	-.193	.287						

Appendix V Table 5:

Moderating effects of parenting style on the link between bereavement status and child problems.

Dependent Variables	**Independent Variables**	**Beta**	***p***	**R^2**	**Adj R^2**	**ΔF**	***p***	***df***	
								***df*1**	***d***
SDQ-Emotional-Problem	Step1			.239	.223	14.728	<.001	5	2
	Constant								
	Parent-Age		.392						
	Parent-Gender	-.004	.946						
		.057	.341						
	ECR-Avoidance	.031	.712						
	ECR-Anxiety	.040	.629						
	Parent-Complicated-Grief	.421	.000						
	Step 2			.245	.222	.898	.409	2	2
	Bereavement-Status	.133	.464						
		.136	.122						
	PS-Overreactivity								
	Step 3			.247	.221	.672	.413	1	2
	Bereavement-StatusXPS-Overreactivity	-.161	.413						
SDQ-Conduct-Problem	Step1		.012	.237	.221	14.523	<.001	5	2
	Constant	-.074	.208						
	Parent-Age	-.090	.136						
	Parent-	.180	.036						

	Gender	-.008	.920						
	ECR-Avoidance	.337	.000						
	ECR-Anxiety								
	Parent-Complicated-Grief								
	Step 2			.248	.225	1.730	.180	2	2
	Bereavement-Status	-.099	.588						
	PS-Overreactivity	.092	.293						
	Step 3			.248	.222	.023	.880	1	2
	Bereavement-StatusXPS-Overreactivity	.030	.880						
SDQ-Hyperactivity	Step1			.238	.222	14.656	<.001	5	2
	Constant		.051						
	Parent-Age	-.030	.610						
	Parent-Gender	.054	.360						
	ECR-Avoidance	.180	.033						
	ECR-Anxiety	.073	.369						
	Parent-Complicated-Grief	.301	.000						
	Step 2			.269	.247	4.800	.009	2	2
	Bereavement-Status	-.231	.198						
		.075	.382						

	PS-Overreactivity								
	Step 3			.269	.244	.122	.727	1	2
	Bereavement-StatusXPS-Overreactivity	.067	.727						
SDQ-Peer-Problem	Step1			.254	.238	15.923	<.001	5	2
	Constant								
	Parent-Age		.134						
	Parent-Gender	-.039	.495						
		-.033	.571						
	ECR-Avoidance	.316	.000						
	ECR-Anxiety	.079	.327						
	Parent-Complicated-Grief	.194	.005						
	Step 2			.277	.255	3.678	.027	2	2
	Bereavement-Status	-.121	.498						
		.051	.556						
	PS-Overreactivity								
	Step 3			.277	.252	.062	.804	1	2
	Bereavement-StatusXPS-Overreactivity	-.048	.804						
SDQ-Prosocial	Step1			.207	.190	12.181	<.001	5	2
	Constant		.113						
	Parent-Age	.020	.736						
	Parent-	.011	.857						

	Gender	-.021	.808						
	ECR-Avoidance	.060	.466						
	ECR-Anxiety	.443	.000						
	Parent-Complicated-Grief								
	Step 2			.213	.189	.936	.393	2	2
	Bereavement-Status	.477	.010						
	PS-Overreactivity	.078	.377						
	Step 3			.231	.204	5.459	.020	1	2
	Bereavement-StatusXPS-Overreactivity	-.463	.020						
SDQ-Total	Step1			.367	.354	27.176	<.001	5	2
	Constant		.017						
	Parent-Age	-.030	.568						
	Parent-Gender	.005	.934						
	ECR-Avoidance	.174	.026						
	ECR-Anxiety	.067	.372						
	Parent-Complicated-Grief	.457	.000						
	Step 2		.	.376	.358	1.668	.191	2	2
	Bereavement-Status	.061	.713						

PS-Overreactivity	.116	.146						
Step 3			.379	.357	.888	.347	1	2
Bereavement-StatusXPS-Overreactivity	-.168	.347						

Appendix V Table 6:

Moderating effects of parenting style on the link between bereavement status and child problems. .

Dependent Variables	**Independent Variables**	**Beta**	***p***	**R^2**	**Adj R^2**	**ΔF**	***p***	***df*1**	***df***
SDQ-Emotional-Problem	Step1			.239	.223	14.728	<.001	5	2
	Constant		.162						
	Parent-Age	-.002	.967						
	Parent-Gender	.055	.364						
	ECR-Avoidance	.050	.543						
	ECR-Anxiety	.042	.621						
	Parent-Complicated-Grief	.420	.000						
	Step 2		. .921	.241	.218	.247	.782	2	2
	Bereavement-Status	-.018	.680						
	PS- Verbosity	.039							
	Step 3			.241	.215	.009	.926	1	2
	Bereavement-StatusXPS-Verbosity	.018	.926						
SDQ-Conduct-Problem	Step1		.016	.237	.221	14.523	<.001	5	2
	Constant	-.083	.161						
	Parent-Age	-.090	.135						
	Parent-Gender	.209	.011						

	ECR-Avoidance	-.024	.772						
	ECR-Anxiety	.349	.000						
	Parent-Complicated-Grief								
	Step 2			.244	.221	1.135	.323	2	2
	Bereavement-Status	.014	.937						
	PS- Verbosity	.103	.278						
	Step 3			.245	.219	.248	.619	1	2
	Bereavement-StatusXPS-Verbosity	-.095	.619						
SDQ-Hyperactivity	Step1			.238	.222	14.656	<.001	5	2
	Constant		.040						
	Parent-Age	-.035	.548						
	Parent-Gender	.055	.354						
	ECR-Avoidance	.200	.014						
	ECR-Anxiety	.057	.491						
	Parent-Complicated-Grief	.311	.000						
	Step 2			.267	.245	4.552	.012	2	2
	Bereavement-Status	-.218	.210						
	PS- Verbosity	.061	.517						

	Step 3			.268	.242	.094	.760	1	2
	Bereavement-StatusXPS-Verbosity	.057	.760						
SDQ-Peer-Problem	Step1			.254	.238	15.923	<.001	5	2
	Constant		.153						
	Parent-Age	-.042	.467						
	Parent-Gender	-.034	.559						
	ECR-Avoidance	.338	.000						
	ECR-Anxiety	.082	.319						
	Parent-Complicated-Grief	.195	.004						
	Step 2			.276	.254	3.534	.031	2	2
	Bereavement-Status	-.034	.844						
	PS- Verbosity	.040	.668						
	Step 3			.278	.253	.607	.437	1	2
	Bereavement-StatusXPS-Verbosity	-.145	.437						
SDQ-Prosocial	Step1			.207	.190	12.181	<.001	5	2
	Constant		.049						
	Parent-Age	.020	.734						
	Parent-Gender	.001	.986						
	ECR-	-.090	.280						

	Avoidance	.049	.564						
	ECR-Anxiety	.432	.000						
	Parent-Complicated-Grief								
	Step 2			.217	.193	1.552	.214	2	2
	Bereavement-Status	.140	.435						
	PS- Verbosity	.122	.207						
	Step 3			.218	.191	.194	.660	1	2
	Bereavement-StatusXPS-Verbosity	-.085	.660						
SDQ-Total	Step1			.367	.354	27.176	<.001	5	2
	Constant								
	Parent-Age		.008						
	Parent-Gender	-.034	.524						
		.001	.989						
	ECR-Avoidance	.177	.018						
	ECR-Anxiety	.057	.456						
	Parent-Complicated-Grief	.459	.000						
	Step 2		.	.377	.358	1.829	.163	2	2
	Bereavement-Status	-.028	.862						
	PS- Verbosity	.097	.262						
	Step 3			.378	.356	.137	.711	1	2
	Bereavement-	-.064	.711						

StatusXPS-Verbosity	

Appendix V Table 7:

Moderating effects of parenting style on the link between bereavement status and child problems. .

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df*1	*df*
SDQ-Emotional-Problem	Step1			.239	.223	14.728	.000	5	2
	Constant		.368						
	Parent-Age	-.007	.907						
	Parent-Gender	.053	.382						
	ECR-Avoidance	.038	.650						
	ECR-Anxiety	.027	.746						
	Parent-Complicated-Grief	.426	.000						
	Step 2			.245	.222	.790	.455	2	2
	Bereavement-Status	.099	.625						
	PS-Total	.118	.197						
	Step 3			.245	.219	.290	.590	1	2
	Bereavement-StatusXPS-Total	-.116	.590						
SDQ-Conduct-Problem	Step1			.237	.221	14.523	.000	5	2
	Constant	-.079	.021						
	Parent-Age	-.091	.180						
	Parent-Gender	.205	.133						

	ECR-Avoidance	-.021	.016						
	ECR-Anxiety	.347	.803						
	Parent-Complicated-Grief		.000						
	Step 2			.244	.221	1.036	.357	2	2
	Bereavement-Status	-.009	.965						
	PS-Total	.084	.357						
	Step 3			.244	.218	.098	.755	1	2
	Bereavement-StatusXPS-Total	-.067	.755						
SDQ-Hyperactivity	Step1			.238	.222	14.656	<.001	5	2
	Constant		.078						
	Parent-Age	-.036	.539						
	Parent-Gender	.050	.394						
	ECR-Avoidance	.181	.030						
	ECR-Anxiety	.053	.523						
	Parent-Complicated-Grief	.311	.000						
	Step 2			.271	.249	5.244	.006	2	2
	Bereavement-Status	-.207	.296						
	PS-Total	.103	.252						

	Step 3			.272	.246	.037	.848	1	2
	Bereavement-StatusXPS-Total	.041	.848						
SDQ-Peer-Problem	Step1			.254	.238	15.923	<.001	5	2
	Constant								
	Parent-Age		.132						
	Parent-Gender	-.040	.484						
	ECR-Avoidance	-.036	.541						
	ECR-Anxiety	.312	.000						
	Parent-Complicated-Grief	.072	.377						
	Step 2	.196	.004	.277	.256	3.790	.024	2	2
	Bereavement-Status	-.162	.411						
	PS-Total	.048	.588						
	Step 3			.277	.252	.000	.999	1	2
	Bereavement-StatusXPS-Total	.000	.999						
SDQ-Prosocial	Step1			.207	.190	12.181	<.001	5	2
	Constant	.023	.106						
	Parent-Age	.005	.704						
	Parent-Gender	-.056	.929						
	ECR-	.058	.515						
		.434							

	Avoidance		.500						
	ECR-Anxiety		.000						
	Parent-Complicated-Grief								
	Step 2			.211	.187	.611	.544	2	2
	Bereavement-Status	.334	.105						
	PS-Total	.095	.303						
	Step 3			.217	.190	1.848	.175	1	2
	Bereavement-StatusXPS-Total	-.298	.175						
SDQ-Total	Step1			.367	.354	27.176	<.001	5	2
	Constant								
	Parent-Age		.020						
	Parent-Gender	-.034	.530						
	ECR-Avoidance	.000	.996						
	ECR-Anxiety	.171	.026						
	Parent-Complicated-Grief	.052	.491						
	Step 2	.461	.000	.378	.359	2.022	.135	2	2
	Bereavement-Status	.026	.887						
	PS-Total	.121	.145						
	Step 3			.379	.358	.406	.525	1	2
	Bereavement-	-.124	.525						

StatusXPS-Total

Appendix V Table 8:

Predictors of SDQ in the bereaved sample.

Dependent Variables	**Independent Variables**	**Beta**	**t**	**p**	**R**	**Adj R^2**	**F**	***p***	***df***
SDQ-Total	Step1				.721	.491	17.608	<.001	8
	Constant			. 048					130
	Parent-Age	-.053	1.992	.403					138
	Parent-Gender	.004	-.838	.947					
	Step 2								
	ECR-Avoidance	.188	2.087	.039					
	Step 3								
	ECR-Anxiety	.249	2.679	.008					
	Step 4								
	Parent-Complicated-Grief	.421	5.561	<.001					
SDQ-Emotional-Problem	Step1				.583	.299	8.356	<.001	8
	Constant		1.490	.139					130
	Parent-Age	-.068	-.915	.362					138
	Parent-Gender	.074	1.017	.311					
	Step 2								
	ECR-	.218	2.005	.047					

	Anxiety Step 3								
	Parent-Complicated-Grief	.426	4.795	.000					
SDQ-Conduct-Problem	Step1				.630	.360	10.693	<.001	8
	Constant		1.483	.140					130
	Parent-Age	-.078	-1.102	.273					138
	Parent-Gender	-.101	-1.445	.151					
	Step 2								
	ECR-Anxiety	.232	2.235	.027					
	Step 3								
	Parent-Complicated-Grief	.324	3.818	.000					
SDQ-Hyperactivity	Step1				.620	.346	10.143	<.001	8
	Constant		-.362	.718					130
	Parent-Age	.023	.314	.754					138
	Parent-Gender	.047	.662	.509					
	Step 2								
	ECR-Avoidance	.246	2.414	.017					
	Step 3								
	ECR-Anxiety	.220	2.097	.038					

	Step 4								
	Parent-Complicated-Grief	.231	2.701	.008					
SDQ-Peer-Problem	Step1				.625	.354	10.434	<.001	8
	Constant		.800	.425					130
	Parent-Age	-.100	-1.396	.165					138
	Parent-Gender	-.041	-.582	.561					
	Step 2								
	ECR-Avoidance	.383	3.770	.000					
	Step 3								
	ECR-Anxiety	.198	1.895	.060					
	Step 4								
	PS-Verbosity	-.225	-2.063	.041					
SDQ-Prosocial	Step1				.512	.217	5.784	<.001	8
	Constant		2.763	.007					130
	Parent-Age	.016	.209	.835					138
	Parent-Gender	.022	.289	.773					
	Step 2								
	Parent-Complicated-Grief	.449	4.785	.000					

Step 3			
PS-Overreactivity	-.338	-3.096	.002
Step 4			
PS-Verbosity	.304	2.534	.012

Appendix V Table 9:

Predictors of CSQ in the bereaved sample.

Dependent Variables	**Independent Variables**	**Beta**	**t**	**p**	**R**
CSQ-Total	Step1				.334
			4.248	.000	
	Constant				
		.032	.365	.716	
	Parent-Age				
		-.059	-.701	.485	
	Parent-Gender				
	Step 2				
		.255	2.019	.046	
	ECR-Anxiety				
	Step 3				
		.292	2.433	.016	
	PS-Overreactivity				
CSQ-Immediate-Response	Step1				.349
			4.018	.000	
	Constant				
		.035	.407	.684	
	Parent-Age				
		-.040	-.477	.634	
	Parent-Gender				
	Step 2				
		.294	2.343	.021	
	ECR-Anxiety				
	Step 3				
		-.289	-2.487	.014	
	PS-Laxness				
	Step 4				
		.298	2.497	.014	
	PS-Overreactivity				
CSQ-Avoidance	Step1				.283
			3.948	.000	
	Constant				
		-.058	-.663	.508	
	Parent-Age				
		-.180	-2.085	.039	
	Parent-Gender				

	Step 2				
	PS-Overreactivity	.241	1.978	.050	
CSQ-Numbing-and-Dissociation	Step1				.349
	Constant		4.388	.000	
	Parent-Age	-.032	-.371	.711	
	Parent-Gender	-.075	-.884	.378	
	Step 2				
	ECR-Anxiety	.299	2.382	.019	
	Step 3				
	PS-Overreactivity	.223	1.872	.063	
	Step 4				
	PS-Verbosity	-.246	-1.874	.063	
CSQ-Increased-Arousal	Step1				.351
	Constant		3.652	.000	
	Parent-Age	.047	.550	.583	
	Parent-Gender	-.003	-.031	.975	
	Step 2				
	ECR-Anxiety	.276	2.204	.029	
	Step 3				
	PS-Laxness	-.235	-2.024	.045	
	Step 4				
	PS-Overreactivity	.239	2.007	.047	
CSQ-Impairment-in-Function	Step1				.315
	Constant		2.056	.042	
	Parent-Age	.117	1.346	.181	
	Parent-Gender	-.079	-.924	.357	

Step 2			
PS-Overreactivity	.367	3.036	.003
Step 3			
PS-Verbosity	-.323	-2.431	.016

Appendix V Table 10:

Predictors of SDQ in the non-bereaved sample

DV	Predictors	Beta	t	p	R	Adj R^2	F	*p*	*df*
SDQ-Total	Step1				.21	.17	14.74	<.001	98
	Constant		1.36	.175					
	Parent Age	.03	.34	.734					97
	Parent Gender	.02	.25	.801					96
	Step 2								
	Parent Compl Grief	.40	4.10	.01					94
SDQ-Emotional	Step1				.58	.29	8.35	.039	98
	Constant		-.58	.562					
	Parent Age	.12	1.33	.185					97
	Parent Gender	.07	.74	.461					96
	Step 2								
	Parent Compl Grief	.33	3.28	.001					94
	Step 3								
	PS Laxness	.28	2.09	.039					93
SDQ-Conduct	Step1				.63	.36	4.76	013	98
	Constant		2.00	.048					
	Parent Age	-.03	-.32	.743					97
	Parent Gender	-.01	.11	.905					96
	Step 2								
	ECR-Anxiety	-.35	-2.52	.013					95

SDQ-Hyperactivity	Step1				.19	.34	7.92	.037	98
	Constant		1.84	.068					97
	Parent Age	-.07	-.78	.435					96
	Parent Gender	.04	.46	.645					95
	Step 2								94
	Parent Compl Grief	.34	3.33	.001					
	Step 3								
	PS-Laxness	.29	2.11	.037					
SDQ-Prosocial	Step1				.17	.13	17.39	<.001	98
	Constant		1.13	.261					97
	Parent Age	.02	.20	.836					96
	Parent Gender	.01	.13	.897					95
	Step 2								
	Parent Compl Grief	.03	4.27	.000					

Appendix V Table 11:

Moderating effects of attachment anxiety on the link between parent complicated grief and child behavioural problems.

Dependent Variables	**Independent Variables**	**Beta**	***p***	**R^2**	**Adj R^2**	**ΔF**	***p***	***df***	
								***df*1**	***df2***
SDQ-Emotional-Problem	Step1			.132	.106	5.107	.001	4	134
	Constant		.010						
	Parent-Age	-.076	.298						
	Parent-Gender	.092	.196						
	ECR-Avoidance	.031	.775						
	PS- Total	.067	.425						
	Step 2			.339	.309	20.627	<.001	2	132
	Parent-Complicated-Grief								
	ECR-Anxiety	-.094	.696						
		-.212	.327						
	Step 3			.365	.331	5.305	.023	1	131
	Parent-Complicated-Grief XECR-Anxiety	.799	.023						
CSQ-Immediate-Response	Step1			.021	-.008	.731	.572	4	134
	Constant		.000						
	Parent-Age	-.006	.942						
	Parent-Gender	-.034	.688						
	ECR-	.012	.925						

	Avoidance	-.117	.247						
	PS- Total								
	Step 2			.047	.004	1.779	.173	2	132
	Parent-Complicated-Grief	-.669	.022						
	ECR-Anxiety	-.338	.191						
	Step 3			.090	.041	6.182	.014	1	131
	Parent-Complicated-GriefXECR-Anxiety	1.032	.014						
CSQ-Reexperiencing	Step1			.014	-.015	.483	.748	4	134
	Constant		.000						
	Parent-Age	.039	.645						
	Parent-Gender	.066	.426						
	ECR-Avoidance	.077	.535						
	PS- Total	-.033	.735						
	Step 2			.057	.014	2.960	.055	2	132
	Parent-Complicated-Grief	-.769	.007						
	ECR-Anxiety	-.656	.010						
	Step 3			.141	.096	12.959	<.001	1	131
	Parent-Complicated-GriefXECR-Anxiety	1.451	.000						
CSQ-Avoidance	Step1			.044	.015	1.537	.195	4	134
	Constant		.000						

	Parent-Age	-.086	.325						
	Parent-Gender	-.152	.076						
	ECR-Avoidance	.086	.501						
	PS- Total	.087	.390						
	Step 2			.050	.007	.436	.647	2	132
	Parent-Complicated-Grief	-.592	.041						
	ECR-Anxiety	-.525	.043						
	Step 3			.093	.044	6.184	.014	1	131
	Parent-Complicated-GriefXECR-Anxiety	1.030	.014						
CSQ-Numbing-Dissociation	Step1			.039	.010	1.355	.253	4	134
	Constant		.000						
	Parent-Age	-.071	.393						
	Parent-Gender	-.044	.589						
	ECR-Avoidance	.098	.423						
	PS- Total	-.108	.263						
	Step 2			.085	.043	3.333	.039	2	132
	Parent-Complicated-Grief	-.865	.002						
	ECR-Anxiety	-.572	.021						
	Step 3			.174	.130	14.082	<.001	1	131
	Parent-Complicated-GriefXECR-	1.484	.000						

	Anxiety								
CSQ-Increased-Arousal	Step1			.041	.012	1.425	.229	4	134
	Constant		.000						
	Parent-Age	.008	.926						
	Parent-Gender	.013	.879						
	ECR-Avoidance	.165	.188						
	PS- Total	-.145	.142						
	Step 2			.073	.031	2.288	.105	2	132
	Parent-Complicated-Grief	-.717	.012						
	ECR-Anxiety	-.445	.079						
	Step 3			.131	.085	8.821	.004	1	131
	Parent-Complicated-GriefXECR-Anxiety	1.204	.004						

Appendix V Table 12:

Moderating effects of attachment avoidance on the link between parent complicated grief and child behavioural problems.

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df*1	*df2*
SDQ-Emotional-Problem	Step1			.219	.196	9.396	<.001	4	134
	Constant		.002						
	Parent-Age	-.087	.229						
	Parent-Gender	.085	.228						
	ECR-Anxiety	.325	.003						
	PS- Total	.089	.290						
	Step 2			.339	.309	11.966	<.001	2	132
	Parent-Complicated-Grief	-.309	.228						
	ECR-Avoidance	-.663	.004						
	Step 3			.383	.350	9.288	.003	1	131
	Parent-Complicated-Grief XECR-Avoidance	1.092	.003						
CSQ-Immediate-Response	Step1			.044	.016	1.551	.191	4	134
	Constant		.000						
	Parent-Age	-.011	.904						
	Parent-Gender	-.048	.577						
		.305	.022						

	ECR-Anxiety	-.120	.243						
	PS- Total Step 2			.047	.004	.193	.824	2	132
	Parent-Complicated-Grief	-.591 -.581	.060 .040						
	ECR-Avoidance Step 3			.076	.026	4.045	.046	1	131
	Parent-Complicated-Grief XECR-Avoidance	.882	.046						
CSQ-Numbing-Dissociation	Step1			.079	.051	2.861	.026	4	134
	Constant		.000						
	Parent-Age	-.070	.415						
	Parent-Gender	-.066	.432						
	ECR-Anxiety	.318	.015						
	PS- Total	-.134	.184						
	Step 2			.085	.043	.461	.632	2	132
	Parent-Complicated-Grief	-.505 -.544	.100 .049						
	ECR-Avoidance Step 3			.115	.067	4.389	.038	1	131
	Parent-Complicated-Grief XECR-Avoidance	.899	.038						

CSQ-Increased-Arousal	Step1			.068	.040	2.432	.051	4	134
	Constant		.000						
	Parent-Age	.003	.974						
	Parent-Gender	-.003	.971						
	ECR-Anxiety	.307	.019						
	PS- Total	-.148	.142						
	Step 2			.073	.031	.375	.688	2	132
	Parent-Complicated-Grief	-.633	.040						
	ECR-Avoidance	-.534	.053						
	Step 3			.113	.065	5.863	.017	1	131
	Parent-Complicated-Grief XECR-Avoidance	1.040	.017						

Appendix V Table 13:

Moderating effects of attachment anxiety on the relationship between parenting style and behavioural problems in bereaved children.

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df*1	*df2*
SDQ-Emotional-Problem	Step1			.315	.295	15.433	<.001	4	134
	Constant		.196						
	Parent-Age	-.037	.606						
	Parent-Gender	.076	.285						
	ECR-Avoidance	.005	.961						
	Parent-Complicated-Grief	.370	.000						
	Step 2			.340	.310	2.418	.093	2	132
	PS-Laxness	.570	.006						
	ECR-Anxiety	.785	.001						
	Step 3			.377	.343	7.780	.006	1	131
	PS-LaxnessXECR-Anxiety	-.916	.006						
SDQ-Prosocial	Step1			.186	.161	7.644	<.001	4	134
	Constant		.341						
	Parent-Age	.072	.369						
	Parent-Gender	.007	.931						
	ECR-	-.037	.736						

	Avoidance	.335	.001						
	Parent-Complicated-Grief								
	Step 2			.197	.161	.942	.393	2	132
	PS-Laxness	.537	.019						
	ECR-Anxiety	.779	.002						
	Step 3			.243	.202	7.864	.006	1	131
	PS-LaxnessXECR-Anxiety	-1.015	.006						
CSQ-Numbing-Dissociation	Step1			.040	.011	1.389	.241	4	134
	Constant		.000						
	Parent-Age	-.074	.395						
	Parent-Gender	-.061	.467						
	ECR-Avoidance	-.103	.381						
	Parent-Complicated-Grief	.140	.178						
	Step 2			.088	.047	3.510	.033	2	132
	PS-Laxness	-.664	.007						
	ECR-Anxiety	-.267	.326						
	Step 3			.118	.071	4.482	.036	1	131
	PS-LaxnessXECR-Anxiety	.827	.036						

Appendix V Table 14:

Moderating effects of attachment avoidance on the relationship between parenting style and behavioural problems in bereaved children.

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df*1	*df2*
SDQ-Prosocial	Step1			.190	.166	7.855	<.001	4	134
	Constant		.699						
	Parent-Age	.056	.485						
	Parent-Gender	.020	.798						
	ECR-Anxiety	.193	.102						
	Parent-Complicated-Grief	.348	.001						
	Step 2			.197	.161	.599	.551	2	132
	PS-Laxness	.413	.093						
	ECR-Avoidance	.345	.147						
	Step 3			.222	.180	4.138	.044	1	131
	PS-LaxnessXECR-Avoidance	-.762	.044						
CSQ-Reexperiencing	Step1			.043	.014	1.504	.205	4	134
	Constant		.000						
	Parent-Age	.032	.708						
	Parent-Gender	.024	.775						
	ECR-Anxiety	.075	.549						

	Parent-Complicated-Grief	.245	.020						
	Step 2			.061	.019	1.282	.281	2	132
	PS-Laxness	-.862	.001						
	ECR-Avoidance	-.739	.004						
	Step 3			.123	.076	9.170	.003	1	131
	PS-LaxnessXECR-Avoidance	1.205	.003						
CSQ-Avoidance	Step1			.049	.021	1.738	.145	4	134
	Constant		.000						
	Parent-Age	-.104	.231						
	Parent-Gender	-.194	.023						
	ECR-Anxiety	-.031	.806						
	Parent-Complicated-Grief	.156	.136						
	Step 2			.049	.006	.005	.995	2	132
	PS-Laxness	-.758	.004						
	ECR-Avoidance	-.686	.007						
	Step 3			.115	.068	9.685	.002	1	131
	PS-LaxnessXECR-Avoidance	1.244	.002						
CSQ-Numbing-	Step1			.054	.025	1.894	.115	4	134

Dissociation	Constant		.000						
	Parent-Age	-.087	.281						
	Parent-Gender	-.094	.237						
	ECR-Anxiety	.147	.212						
	Parent-Complicated-Grief	.203	.041						
	Step 2			.088	.047	2.518	.084	2	132
	PS-Laxness	-1.253	.000						
	ECR-Avoidance	-1.046	.000						
	Step 3			.218	.176	21.712	<.001	1	131
	PS-LaxnessXECR-Avoidance	1.750	.000						
CSQ-Increased-Arousal	Step1			.041	.012	1.435	.226	4	134
	Constant		.000						
	Parent-Age	.008	.928						
	Parent-Gender	-.012	.885						
	ECR-Anxiety	.173	.164						
	Parent-Complicated-Grief	.119	.250						
	Step 2			.093	.052	3.779	.025	2	132
	PS-Laxness	-.861	.001						
	ECR-Avoidance	-.530	.035						

	Step 3			.136	.089	6.470	.012	1	131
	PS-LaxnessXECR-Avoidance	1.004	.012						
CSQ-Impairment-in-Function	Step1			.016	-.014	.529	.714	4	134
	Constant		.000						
	Parent-Age	.061	.482						
	Parent-Gender	-.088	.304						
	ECR-Anxiety	-.030	.814						
	Parent-Complicated-Grief	.121	.250						
	Step 2			.023	-.021	.527	.591	2	132
	PS-Laxness	-.923	.001						
	ECR-Avoidance	-.707	.006						
	Step 3			.101	.053	11.359	.001	1	131
	PS-LaxnessXECR-Avoidance	1.357	.001						

Table 15:

Moderating effects of attachment anxiety on the relationship between parenting style and behavioural problems in bereaved children.

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df*	
								*df*1	*df2*
SDQ-Prosocial	Step1			.186	.161	7.644	<.001	4	134
	Constant		.524						
	Parent-Age	.058	.460						
	Parent-Gender	.009	.909						
	ECR-Avoidance	-.044	.695						
	Parent-Complicated-Grief	.350	.000						
	Step 2			.225	.190	3.326	.039	2	132
	PS-Overreactivity	.404	.072						
	ECR-Anxiety	.892	.002						
	Step 3			.273	.235	8.769	.004	1	131
	P-OverreactivityXECR-Anxiety	-1.081	.004						
CSQ-Impairment-in-Function	Step1			.016	-.014	.533	.712	4	134
	Constant		.006						
	Parent-Age	.073	.413						
	Parent-Gender	-.077	.369						
	ECR-Avoidance	-.005	.967						

	Parent-Complicated-Grief	.078	.471					
	Step 2			.032	-.012	1.097	.337	2	132
	PS-Overreactivity	-.331	.194					
	ECR-Anxiety	-.563	.076					
	Step 3			.062	.012	4.211	.042	1	131
	P-OverreactivityXECR-Anxiety	.851	.042					

Appendix V Table 16:

Moderating effects of attachment avoidance on the relationship between parenting style and behavioural problems in bereaved children.

Dependent Variables	**Independent Variables**	**Beta**	***p***	**R^2**	**Adj R^2**	**ΔF**	***p***	***df*1**	***df2***
SDQ-Prosocial	Step1			.190	.166	7.855	<.001	4	134
	Constant		.908						
	Parent-Age	.040	.616						
	Parent-Gender	.005	.946						
	ECR-Anxiety	.117	.300						
	Parent-Complicated-Grief	.397	.000						
	Step 2			.225	.190	2.971	.055	2	132
	PS-Overreactivity	.234	.317						
	ECR-Avoidance	.457	.072						
	Step 3			.248	.208	4.115	.045	1	131
	PS-OverreactivityXECR-Avoidance	-.771	.045						

Appendix V Table 17:

Moderating effects of attachment anxiety

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df* *df*1	*df2*
SDQ-Emotional-Problem	Step1			.295	2.046	15.433	<.001	4	134
	Constant		.636						
	Parent-Age	-.039	.601						
	Parent-Gender	.077	.279						
	ECR-Avoidance	-.025	.805						
	Parent-Complicated-Grief	.386	.000						
	Step 2			.309	2.025	2.344	.100	2	132
	PS-Verbosity	.392	.050						
	ECR-Anxiety	.597	.006						
	Step 3			.325	2.002	4.119	.044	1	131
	PS-VerbosityXECR-Anxiety	-.629	.044						
SDQ-Prosocial	Step1			.186	.161	7.644	<.001	4	134
	Constant								
	Parent-Age		.128						
	Parent-Gender	.090	.255						
	ECR-Avoidance	-.002	.980						
	Parent-Complicated-Grief	-.095	.371						

		.327	.001						
	Step 2			.197	.161	.958	.386	2	132
	PS-Verbosity	.759	.000						
	ECR-Anxiety	.846	.000						
	Step 3			.271	.232	13.143	<.001	1	131
	P-VerbosityXECR-Anxiety	-1.199	.000						
CSQ-Avoidance	Step1			.049	.020	1.716	.150	4	134
	Constant		.000						
	Parent-Age	-.109	.219						
	Parent-Gender	-.169	.049						
	ECR-Avoidance	.014	.909						
	Parent-Complicated-Grief	.123	.246						
	Step 2			.051	.008	.172	.842	2	132
	PS-Verbosity	-.513	.032						
	ECR-Anxiety	-.426	.098						
	Step 3			.083	.034	4.589	.034	1	131
	P-VerbosityXECR-Anxiety	.794	.034						
CSQ-Numbing-Dissociation	Step1			.040	.011	1.389	.241	4	134
	Constant		.000						

	Parent-Age	-.092	.285					
	Parent-Gender	-.080	.334					
	ECR-Avoidance	-.064	.580					
	Parent-Complicated-Grief	.142	.167					
	Step 2			.094	.052	3.913	.022	2	132
	PS-Verbosity	-.766	.001					
	ECR-Anxiety	-.309	.215					
	Step 3			.140	.094	7.080	.009	1	131
	P-VerbosityXECR-Anxiety	.955	.009					

Appendix V Table 18:

Moderating effects of attachment avoidance on the relationship between parenting style and behavioural problems in bereaved children.

Dependent Variables	**Independent Variables**	**Beta**	***p***	**R^2**	**Adj R^2**	**ΔF**	***p***	***df***	
								***df*1**	***df2***
SDQ-Prosocial	Step1			.190	.166	7.855	<.001	4	134
	Constant		.273						
	Parent-Age	.066	.406						
	Parent-Gender	-.005	.946						
	ECR-Anxiety	.154	.183						
	Parent-Complicated-Grief	.328	.001						
	Step 2			.197	.161	.615	.542	2	132
	PS-Verbosity	.680	.003						
	ECR-Avoidance	.494	.031						
	Step 3			.250	.210	9.212	.003	1	131
	PS-VerbosityXECR-Avoidance	-1.056	.003						
CSQ-Reexperiencing	Step1			.043	.014	1.504	.205	4	134
	Constant		.000						
	Parent-Age	.026	.760						
	Parent-Gender	.039	.638						
	ECR-Anxiety	.121	.331						

	Parent-Complicated-Grief	.244	.021						
	Step 2			.060	.017	1.181	.310	2	132
	PS-Verbosity	-.795	.001						
	ECR-Avoidance	-.713	.004						
	Step 3			.121	.074	9.118	.003	1	131
	PS-VerbosityXECR-Avoidance	1.138	.003						
CSQ-Avoidance	Step1			.049	.021	1.738	.145	4	134
	Constant		.000						
	Parent-Age	-.106	.221						
	Parent-Gender	-.164	.051						
	ECR-Anxiety	.021	.865						
	Parent-Complicated-Grief	.155	.143						
	Step 2			.051	.008	.130	.878	2	132
	PS-Verbosity	-.725	.003						
	ECR-Avoidance	-.635	.011						
	Step 3			.114	.066	9.210	.003	1	131
	PS-VerbosityXECR-Avoidance	1.148	.003						
CSQ-Numbing-Dissociation	Step1			.054	.025	1.894	.115	4	134
	Constant		.000						

	Parent-Age	-.093	.258						
	Parent-Gender	-.073	.356						
	ECR-Anxiety	.225	.059						
	Parent-Complicated-Grief	.192	.056						
	Step 2			.094	.052	2.916	.058	2	132
	PS-Verbosity	-1.117	.000						
	ECR-Avoidance	-.937	.000						
	Step 3			.206	.164	18.583	<.001	1	131
	PS-VerbosityXECR-Avoidance	1.543	.000						
CSQ-Increased-Arousal	Step1			.041	.012	1.435	.226	4	134
	Constant		.000						
	Parent-Age	.003	.972						
	Parent-Gender	-.016	.847						
	ECR-Anxiety	.217	.085						
	Parent-Complicated-Grief	.108	.306						
	Step 2			.076	.034	2.518	.085	2	132
	PS-Verbosity	-.707	.004						
	ECR-Avoidance	-.450	.071						
	Step 3			.110	.062	4.912	.028	1	131
	PS-	.840	.028						

	VerbosityXECR-Avoidance								
CSQ-Impairment-in-Function	Step1			.016	-.014	.529	.714	4	134
	Constant		.000						
	Parent-Age	.060	.493						
	Parent-Gender	-.067	.431						
	ECR-Anxiety	.039	.757						
	Parent-Complicated-Grief	.108	.308						
	Step 2			.035	-.009	1.336	.266	2	132
	PS-Verbosity	-.837	.001						
	ECR-Avoidance	-.586	.020						
	Step 3			.098	.050	9.138	.003	1	131
	PS-VerbosityXECR-Avoidance	1.154	.003						

Appendix V Table 19:

Moderating effects of parental complicated grief on the relationship between parenting style and behavioural problems in bereaved children.

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df* *df1*	*df2*
SDQ-Hyperactivity	Step1			.344	.325	17.598	<.001	4	134
	Constant		.289						
	Parent-Age	.016	.824						
	Parent-Gender	.046	.500						
	ECR-Avoidance	.240	.018						
	ECR-Anxiety	.261	.012						
	Step 2			.384	.356	4.232	.017	2	132
	Parent-Complicated-Grief	-.276	.282						
	PS-Overreactivity	-.243	.138						
	Step 3			.404	.372	4.410	.038	1	131
	Parent-Complicated-GriefX PS-Overreactivity	.661	.038						
SDQ-Prosocial	Step1			.089	.062	3.290	.013	4	134
	Constant	.032	.497						
	Parent-Age	.003	.688						
	Parent-								

	Gender	.006	.974						
	ECR-Avoidance	.093	.955						
	ECR-Anxiety		.416						
	Step 2			.225	.190	11.530	<.001	2	132
	Parent-Complicated-Grief	.985	.001						
	PS-Overreactivity	.131	.474						
	Step 3			.250	.210	4.385	.038	1	131
	Parent-Complicated-GriefXPS-Overreactivity	-.739	.038						
CSQ-Immediate-Response	Step1			.026	-.003	.889	.472	4	134
	Constant		.000						
	Parent-Age	.003	.972						
	Parent-Gender	-.058	.497						
	ECR-Avoidance	-.191	.130						
	ECR-Anxiety	.260	.043						
	Step 2			.029	-.015	.195	.823	2	132
	Parent-Complicated-Grief	-.717	.027						
		-.355	.083						

PS-Overreactivity								
Step 3			.068	.018	5.532	.020	1	131
Parent-Complicated-GriefXPS-Overreactivity	.925	.020						

Appendix V Table 20:

Moderating effects of parental complicated grief on the relationship between parenting style and behavioural problems in bereaved children.

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df* *df1*	*df2*
CSQ-Numbing-Dissociation	Step1			.054	.026	1.906	.113	4	134
	Constant		.000						
	Parent-Age	-.073	.393						
	Parent-Gender	-.066	.427						
	ECR-Avoidance	-.034	.768						
	ECR-Anxiety	.266	.030						
	Step 2			.088	.047	2.495	.086	2	132
	Parent-Complicated-Grief	-.653	.024						
	PS-Laxness	-.684	.001						
	Step 3			.139	.093	7.731	.006	1	131
	Parent-Complicated-GriefXPS-Laxness	.970	.006						
CSQ-Impairment-in-Function	Step1			.015	-.014	.513	.727	4	134
	Constant		.001						
	Parent-Age	.071	.424						
	Parent-	-.066	.446						

	Gender	.080	.506					
	ECR-Avoidance	.063	.619					
	ECR-Anxiety							
	Step 2			.023	-.021	.560	.573	2	132
	Parent-Complicated-Grief	-.582	.053					
	PS-Laxness	-.509	.017					
	Step 3			.058	.008	4.864	.029	1	131
	Parent-Complicated-GriefXPS-Laxness	.805	.029					

Appendix V Table 21:

Moderating effects of parental complicated grief on the relationship between parenting style and behavioural problems in bereaved children.

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df* *df1*	*df2*
SDQ-Prosocial	Step1			.089	.062	3.290	.013	4	134
	Constant		.841						
	Parent-Age	.059	.458						
	Parent-Gender	.012	.876						
	ECR-Avoidance	-.139	.203						
	ECR-Anxiety	.121	.296						
	Step 2			.197	.161	8.882	<.001	2	132
	Parent-Complicated-Grief	1.013	.000						
	PS-Verbosity	.451	.010						
	Step 3			.237	.197	6.855	.010	1	131
	Parent-Complicated-GriefXPS-Verbosity	-.800	.010						
CSQ-Numbing-Dissociation	Step1			.054	.026	1.906	.113	4	134
	Constant		.000						
	Parent-Age	-.068	.430						
	Parent-	-.091	.277						

	Gender	-.028	.808					
	ECR-Avoidance	.269	.032					
	ECR-Anxiety							
	Step 2			.094	.052	2.892	.059	2	132
	Parent-Complicated-Grief	-.414	.128					
		-.527	.005					
	PS-Verbosity							
	Step 3			.120	.073	3.913	.050	1	131
	Parent-Complicated-GriefXPS-Verbosity	.649	.050					

Appendix V Table 22:

Moderating effects of parental complicated grief on the relationship between parenting style and behavioural problems in bereaved children.

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df* *df1*	*df2*
SDQ-Hyperactivity	Step1			.049	.009	1.234	.301	4	96
	Constant		.871						
	Parent-Age	-.073	.431						
	Parent-Gender	.102	.283						
	ECR-Avoidance	-.043	.765						
	ECR-Anxiety	.036	.789						
	Step 2			.160	.107	6.229	.003	2	94
	Parent-Complicated-Grief	.985	.000						
	PS-Overreactivity	.756	.001						
	Step 3			.225	.167	7.806	.006	1	93
	Parent-Complicated-GriefXPS-Overreactivity	-.994	.006						
SDQ-Peer-Problems	Step1			.112	.075	3.031	.021	4	96
	Constant	.064	.411						
	Parent-Age	-.025	.491						
	Parent-								

	Gender	.129	.793					
	ECR-Avoidance	.047	.382					
	ECR-Anxiety		.727					
	Step 2			.161	.108	2.765	.068	2	94
	Parent-Complicated-Grief	.735	.006					
	PS-Overreactivity	.594	.011					
	Step 3			.203	.143	4.848	.030	1	93
	Parent-Complicated-GriefXPS-Overreactivity	-.795	.030					

Appendix V Table 23:

The moderating effects of parental complicated grief on the relationship between parenting style and behavioural problems in bereaved children.

Dependent Variables	Independent Variables	Beta	*p*	R^2	Adj R^2	ΔF	*p*	*df*	
								*df*1	*df*
SDQ-Hyperactivity	Step1			.049	.009	1.234	.301	4	96
	Constant		.403						
	Parent-Age	-.070	.448						
	Parent-Gender	.002	.980						
	ECR-Avoidance	.016	.905						
	ECR-Anxiety	-.034	.792						
	Step 2			.152	.098	5.700	.005	2	94
	Parent-Complicated-Grief	1.187	.000						
	PS-Verbosity	.916	.000						
	Step 3			.247	.191	11.794	.001	1	93
	Parent-Complicated-GriefXPS-Verbosity	-1.259	.001						
SDQ-Peer-Problems	Step1			.112	.075	3.031	.021	4	96
	Constant		.296						
	Parent-Age	.065	.495						
	Parent-	-.101	.302						

	Gender	.177	.213					
	ECR-Avoidance	-.012	.931					
	ECR-Anxiety							
	Step 2			.157	.103	2.511	.087	2	94
	Parent-Complicated-Grief	.809	.005					
	PS-Verbosity	.650	.010					
	Step 3			.204	.144	5.435	.022	1	93
	Parent-Complicated-GriefXPS-Verbosity	-.879	.022					